Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00028-140

Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California

April 4, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CS	controlled substances
EOC	environment of care
facility	VA Palo Alto Health Care System
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
JC	Joint Commission
MDRO	multidrug-resistant organisms
MH	mental health
OIG	Office of Inspector General
PI	performance improvement
PPE	personal protective equipment
PR	peer review
PRC	Peer Review Committee
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, CA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of February 7, 2011.

Review Results: The review covered seven activities. We made no recommendations in the following activity:

- Environment of Care

The facility's reported accomplishments were improved eye and vision care and achievements in customer service and patient satisfaction.

Recommendations: We made recommendations in the following six activities:

Quality Management: Notify the Peer Review Committee when corrective actions are completed, and strengthen processes to ensure documentation of patient assessment prior to moderate sedation includes all required elements. Revise the emergency event record form to include all required elements, and use the form for individual events and trend analysis.

Physician Credentialing and Privileging: Revise facility policy and service-specific proctoring guidelines to comply with Focused Professional Practice Evaluation requirements for all new hires. Require that two efforts to obtain verification of clinical privileges held at other institutions be made and documented in the credentialing and privileging folders.

Management of Test Results: Communicate normal test results to patients within the specified timeframe, and ensure consistent documentation of times that pathology providers report critical pathology results to ordering providers.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to patients infected or colonized with multidrug-resistant organisms and their families, and document it. Ensure employees receive annual multidrug-resistant organisms education, and document it.

Coordination of Care: Provide written advance directive notification to patients, and document it in the medical record.

Medication Management: Ensure that pharmacy staff wear clean inner gloves when labeling and placing the chemotherapy infusion into the transport bag.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through December 2011 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California,* Report

No. 08-00786-116, April 23, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 788 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Research Led to Improved Eye and Vision Care

Two facility researchers have significantly improved the quality of life for veterans with eye and vision injuries incurred during their deployment in Iraq, Afghanistan, and other areas in the world. By bringing together research and clinical care, they were able to develop eye and vision injury detection and improved examination techniques for diagnosing eye injuries as well as a clinical team approach to rehabilitation care programs to treat those injuries.

Most Customer-Friendly Choice Award

In 2010, the facility received the Most Customer-Friendly Choice Award from the American Alliance of Healthcare Providers. The award recognized the facility's efforts in implementing an excellent health care program that successfully resulted in courteous, compassionate, and caring service for patients, families, and the community. High patient and employee satisfaction enabled the facility to obtain this recognition.

High Patient Satisfaction Scores

In FY 2010, the facility scored significantly higher than the national average on patient satisfaction on all 27 items measured by the survey instrument. It had the highest scores in both inpatient and outpatient settings of any facility in VISN 21. (See Appendix C, Table 1 for further details.)

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

PR. VHA requires that the PRC receive notification upon completion of corrective actions.[1] In 5 of the 10 cases reviewed, we found that the PRC tracking log did not indicate that corrective actions, such as provider counseling, guideline review, and referral for service-specific PR, had been completed even though the facility indicated that these actions were complete.

Moderate Sedation. VHA requires facilities to document patient assessment prior to use of moderate sedation for a procedure.[2] We found documentation of all required elements in only 7 of the 10 outpatient records reviewed. Missing elements included airway assessment, review of allergies, and re-evaluation immediately before sedation.

Resuscitation and Its Outcomes. VHA requires facilities to review specific elements of performance in responding to each resuscitation episode and to analyze trends in aggregate.[3] Because the emergency event record form lacked the required elements, such as errors or deficiencies in technique, equipment malfunction, and delays in initiating CPR, the facility was unable to review required elements and analyze trends.

Recommendations

1. We recommended that the PRC be notified when corrective actions are completed.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

2. We recommended that processes be strengthened to ensure that documentation of patient assessment prior to moderate sedation includes all required elements.

3. We recommended that the individual emergency event record form be revised to include all required elements and that the form be used for individual events and trend analysis in aggregate.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 28 physicians' C&P files and profiles and found that licenses were current. However, we identified the following areas that needed improvement.

FPPE. VHA requires that FPPEs be initiated for all physicians who have been newly hired.[4] Facility policy states that proctoring/FPPE may be waived upon service chief request if the physician demonstrated clinical competence in his or her area at affiliated institutions or is an expert in that field. Six of the nine available service-level guidelines also state that proctoring/FPPE may be waived for physicians who served as a resident or fellow. Furthermore, service-level guidelines for new hires were not consistent with facility policy regarding FPPE processes and forms.

Verification of Clinical Privileges. VHA requires the facility to make a minimum of two efforts to obtain verification of current clinical privileges held elsewhere and to document this in the C&P folder.[5] The verification must include whether the privileges are in good standing with no adverse actions for the specified period. Of the 28 physician C&P files reviewed, only 3 had documentation verifying that the provider's current privileges were in good standing. Although the facility made initial attempts to obtain this information for the remaining physicians, it did not make second attempts when documentation was not received.

Recommendations

4. We recommended that facility policy and service-specific proctoring guidelines be revised to comply with VHA requirements for FPPE for all new hires.

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[5] VHA Handbook 1100.19.

5. We recommended that two efforts to obtain verification of clinical privileges held at other institutions be made and documented in C&P folders.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[6]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following areas that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[7] We reviewed the medical records of 67 patients who had normal results and found that only 47 (70 percent) records contained documented evidence that the facility had communicated the results to the patients within the specified timeframe.

Documentation of Ordering Provider Notification. VHA requires that diagnostic clinicians (laboratory, pathology, and radiology) document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[8] We reviewed the medical records of 20 patients who had critical or abnormal pathology results and found that pathology clinicians documented the time the ordering provider was notified in only 15 of the 20 records.

Recommendations

6. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

7. We recommended that pathology clinicians consistently document the time critical or abnormal pathology results were communicated to ordering providers.

[6] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[7] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[8] VHA Directive 2009-019.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the medical/surgical (2A) and SCI (7E and 7F) units at the Palo Alto division and the CLC units at the Livermore and Menlo Park divisions, and we interviewed employees. We did not identify any deficits in either the inspections or staff interviews. However, we identified the following areas that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[9] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed 25 medical records and found that only 8 had documented evidence of MDRO education.

Employee Training. Facility policy requires designated staff to have annual MDRO training. We reviewed the training records of 42 designated employees and found that only 24 (57 percent) of the records had documentation of annual MDRO education.

Recommendations

8. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

9. We recommended that employees received annual MDRO education and that the training be consistently documented.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following area that needed improvement.

Advance Directive Notification. VHA requires that the facility provide patients with written notification at each admission to a VHA facility of their right to accept or refuse medical

[9] Colonization is the presence of bacteria in the body without causing clinical infection.

treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[10] This notification must include the statement that VA does not discriminate against patients based on whether or not they have an advance directive and must be documented in the patient's medical record. We reviewed 10 medical records, and none had documentation of advance directive notification.

Recommendation

10. We recommended that written advance directive notification be provided to patients and documented in the medical record.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the infusion clinic, and we interviewed employees. We identified the following area that needed improvement.

Clean Inner Gloves. The American Society of Health-System Pharmacists requires that staff wear clean inner gloves when labeling and placing the final preparation into the transport bag. The pharmacy technician preparing the chemotherapy infusion had clean inner gloves but did not remove the contaminated outer gloves prior to affixing the label to the chemotherapy infusion bag. The pharmacy technician removed the outer gloves only after placing the chemotherapy infusion into the transport bag.

Recommendation

11. We recommended that pharmacy staff wear clean inner gloves when labeling and placing the chemotherapy infusion into the transport bag.

Review Activity Without Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

At the Palo Alto division, we inspected selected inpatient (medical, surgical, intensive care, MH, CLC, polytrauma, and

[10] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

SCI) units, the outpatient surgical unit, primary care clinics, the women's health clinic, and the radiology department. At the Livermore division, we inspected the CLC unit, selected primary and specialty care clinics, and the radiology department. At the Menlo Park division, we inspected the CLC units in buildings 331 and 360. The facility maintained a generally clean and safe environment. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–20, for the full text of the Directors' comments.) We consider Recommendations 5, 7, and 11 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[11]		
Type of Organization	Tertiary care medical center	
Complexity Level	1A	
VISN	21	
CBOCs	San Jose, CA Monterey, CA Capitola, CA Stockton, CA Modesto, CA Sonora, CA Fremont, CA	
Veteran Population in Catchment Area	255,348	
Type and Number of Total Operating Beds:		
• **Hospital, including PRRTP**	301	
• **CLC/Nursing Home Care Unit**	360	
• **Other (Domiciliary)**	172	
Medical School Affiliation(s)	Stanford University School of Medicine	
• **Number of Residents**	750	
	Current FY (through December 2010)	**FY 2010**
Resources (in millions):		
• **Total Medical Care Budget**	$811.8	$755.1
• **Medical Care Expenditures**	$205.5	$742.7
Total Medical Care FTE	3,628.5	3,555.9
Workload: (business)		
• **Number of Station Level Unique Patients**	40,774	62,566
• **Inpatient Days of Care:**		
o **Acute Care**	18,448	74,978
o **CLC/Nursing Home Care Unit**	25,538	103,523
Hospital Discharges	2,482	9,899
Total Average Daily Census (including all bed types)	665.4	699.4
Cumulative Occupancy Rate	75.4%	80.4%
Outpatient Visits	171,093	683,907

[11] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Review all physicians' privileges to ensure that current privileges match current work, privileges are signed off by the appropriate chiefs, reference sources reflect correct privileges, and changes in work assignments are accompanied by commensurate privilege changes.	Service chiefs review all requested privileges during initial appointment and reappointments to ensure that current privileges match current work. The medical staff office monitors signatures and privilege changes due to change in work assignments.	Y	N
2. Develop a mechanism to discuss all cases where review processes might identify adverse events, and document full disclosure as appropriate.	A tracking system was developed and implemented. Adequate processes are in place to appropriately consider cases for disclosure.	Y	N
3. Develop plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that show compliance with plans.	Service chiefs have developed service-specific criteria, and profiles contain adequate data.	Y	N
Pharmacy Operations and CS Inspections			
4. Ensure that weekly inventory checks are performed in all appropriate areas and that the checklist and local policy are updated.	Facility policy was revised, eliminating the weekly inventory or verification for automated units. This is consistent with VHA Handbook 1108.02.	Y	N
5. Appoint a sufficient number of CS inspectors to meet all program requirements.	The facility has a sufficient number of trained CS inspectors to support the CS Inspections program.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Reappoint CS inspectors according to VHA policy, and ensure all CS inspectors complete required annual certifications and possess current letters of designation.	Inspectors have current certifications and appointment letters as required. (There have been no reappointments.)	Y	N
Medication Management			
7. Ensure nurses consistently document the effectiveness of all pain medications within the required timeframe.	Pain effectiveness training outlining documentation requirements is provided to licensed nursing staff during orientation and annually. Periodic audits of pain effectiveness documentation show good compliance.	Y	N

VHA Satisfaction Surveys

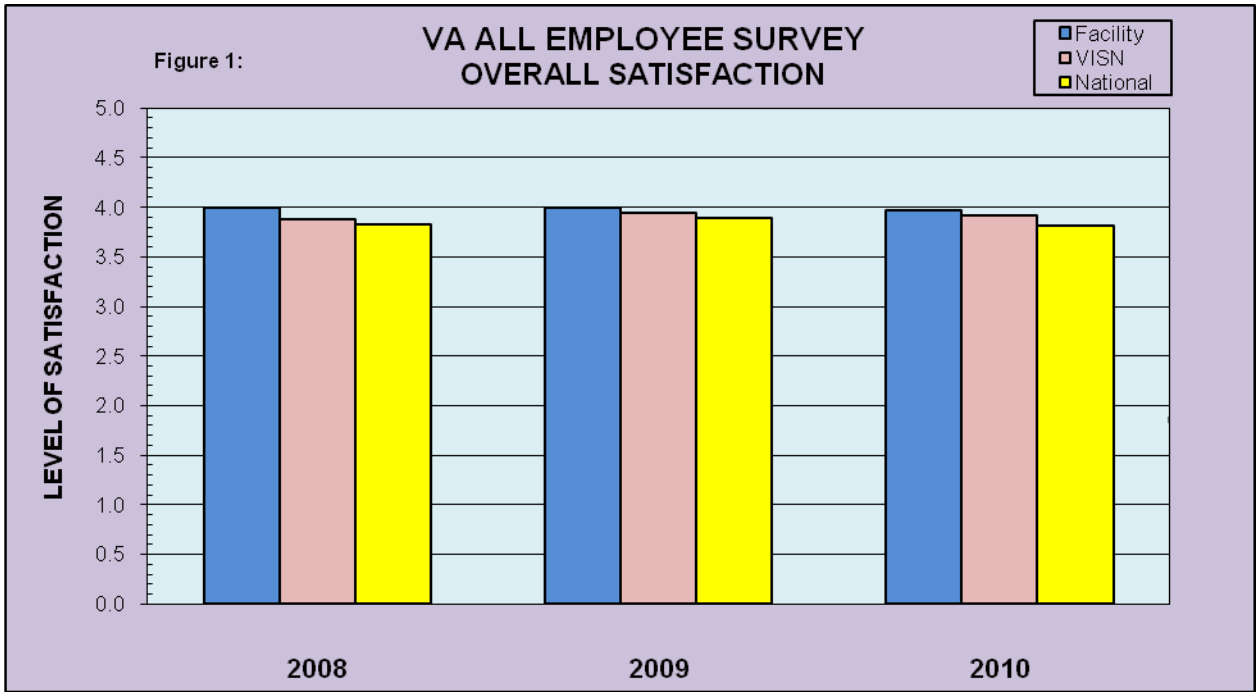
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	**Inpatient Score Quarter 2**	**Inpatient Score Quarter 3**	**Inpatient Score Quarter 4**	**Outpatient Score Quarter 1**	**Outpatient Score Quarter 2**	**Outpatient Score Quarter 3**	**Outpatient Score Quarter 4**
Facility	73.8	72.7	76.8	77.4	63.2	63.8	63.0	61.2
VISN	70.5	65.7	72.9	70.2	57.8	58.6	59.3	56.9
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[12] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	12.87	8.09	15.89	18.97	18.34	15.53
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[12] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 25, 2011

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA CO 10B5 Staff)

1. Thank you for the opportunity to review the draft OIG CAP report for the Palo Alto Health Care System site visit that was conducted in February 2011. We concur with the recommendations, and will ensure completion as described in the attached plan by the established target dates.

2. If you have any questions regarding the attached response or action for recommendations please contact Ms Terry Sanders, VISN 21 Associate Quality Management Officer at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 25, 2011

From: Director, VA Palo Alto Health Care System

Subject: **CAP Review of the VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, Sierra Pacific Network (10N21)

1. VAPHCS appreciates the opportunity to review the OIG report on the CAP Review of the VA Palo Alto Health Care System.

2. Please find attached our response to each recommendation provided in the report.

3. If you have any questions regarding the response to the recommendations in the report, feel free to call me at (508) 858-3939.

(original signed by:)
Elizabeth Joyce Freeman
Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the PRC be notified when corrective actions are completed.

Concur

Target date for completion: December 31, 2011.

A tracking log for meeting minutes will be provided to update members on the completion of action items. Audits will be conducted quarterly times for three quarters to ensure the action grid reflects closure of all open action items.

Recommendation 2. We recommended that processes be strengthened to ensure that documentation of patient assessment prior to moderate sedation includes all required elements.

Concur

Target date for completion: September 30, 2011.

The Cardiology Section Chief has implemented a plan to address the recommendation regarding allergy review and re-evaluation immediately prior to sedation.

The pre-assessment template will be modified to include an allergy review. All physicians and nurses received supplemental education regarding the specific requirements outlined in the Moderate Sedation Policy 11-09-46 on Feb 10, 2011. Monthly documentation audits were increased to a weekly basis with a target of 100% compliance. The audit will consist of two cases weekly. This data will consistently be reviewed for modification in the monthly QA review in the Cardiology department. Target completion date: May 30, 2011.

The Radiology Section Chief has implemented a plan to address the recommendation regarding airway assessment prior to sedation.

Radiology has contacted both Vascular Surgery Service and Nursing Service to reinforce the importance of proper pre-procedure evaluation and documentation. The Interventional Radiology charge nurses will audit 100% of Vascular Surgery moderate sedation cases for one quarter beginning in April, 2011 to achieve 100% compliance with all elements of the pre-procedure checklist. This data will consistently be reviewed for modification in the quarterly Surgical and other Procedure Committee (SOIP). Target completion date: June 30, 2011.

Additionally, random audits of pre-procedure moderate sedation assessment documentation will be conducted in all moderate sedation units for two quarters beginning April 1, 2011 with a target of 100% compliance. Target completion date: September 30, 2011.

Recommendation 3. We recommended that the individual emergency event record form be revised to include all required elements and that the form be used for individual events and trend analysis in aggregate.

Concur

Target date for completion: September 30, 2011.

The Emergency Event Record form was revised February 10, 2011. We have re-introduced the QA elements of CPR technique and equipment problems onto the form. An audit of each event will be completed to ensure this information is captured 100% of the time for 2 quarters beginning April, 2011.

Recommendation 4. We recommended that facility policy and service-specific proctoring guidelines be revised to comply with VHA requirements for FPPE for all new hires.

Concur

Target date for completion: June 30, 2011.

Local policy will be revised and a new proctoring policy for all clinical services will be implemented. The individual Service Chiefs of clinical services are responsible for monitoring of all proctoring/FPPE plans. Once the proctor assesses that the applicant has fulfilled the proctoring process, a packet will be composed by the Administrative Officer of the service, which is signed by the proctor and service chief requesting conversion to full medical staff. This packet will be forwarded to the Medical Staff Office (MSO) to be presented at the Professional Standards Board committee and Medical Executive Board for approval by the Chief of Staff and Director. The MSO will track proctoring through VistA and will notify services when proctoring needs to be completed (conversion) or if extension of proctoring is necessary. Beginning April 1, 2011, this practice will be audited for one quarter to achieve 100% compliance.

Recommendation 5. We recommended that two efforts to obtain verification of clinical privileges held at other institutions be made and documented in C&P folders.

Concur

Target date for completion: Consider this closed.

If privileges are not included with each facility's response, MSO will contact the facility to verbally verify that the privileges are in good standing. The verbal response will be

documented and placed in the Credentialing and Privileging folder. The document is then scanned into VetPro and subsequently closed out.

Recommendation 6. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: September 30, 2011.

VAPAHCS currently follows our lab results directive. A Patient Health Journal is shared with the Veteran that includes lab results. Patients are also notified within the 14 day time period by phone and/or letter.

Auditing of compliance will occur using our Ambulatory Care clinical review process. Notification to patients of normal test results is an item that has been added to the review form. This is the same process that is used for medical record compliance and clinical practice guideline compliance. The audit consists of five medical record reviews/provider/quarter. We will continue to audit indefinitely but will report audit findings for the next two quarters to the Medical Executive Board.

Recommendation 7. We recommended that pathology clinicians consistently document the time critical or abnormal pathology results were communicated to ordering providers.

Concur

Target date for completion: Consider this closed.

Effective January 1, 2011, Pathology and Laboratory Medicine Service (PLMS) policy was changed to require that critical or abnormal pathology results be reported to the ordering provider team verbally. PLMS has identified new/first-time cancer diagnoses as a critical or abnormal pathology. The report must include who was notified, by whom and when notification occurred. All staff was educated about this requirement. Monthly monitoring began in January 2011, with a goal of 100% compliance.

Cases signed out in January, 2011: 28 cases had documented notification, 3 cases had no documentation (90% compliance).

Cases signed out in February 2011: 26 cases had documented notification, 2 cases had no documentation (93% compliance).

Cases signed out as of March 15, 2011: 10 cases had documented notification, 0 cases had no documentation (100%).

Monthly auditing will continue indefinitely with a compliance goal of 100% and the results will be reported to the PLMS QA Committee and will be included in the PLMS annual report to the MEB. This action item has been completed.

Recommendation 8. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and that the education be documented.

Concur

Target date for completion: September 30, 2011.

Infection Control will develop a procedure to identify inpatients with positive tests for MDRO and communicate with appropriate units/providers to provide the necessary education. A standardized patient education template is being developed that will capture documentation of MDRO education given to all patients testing positive.

Once these two processes are developed, Infection Control will coordinate an educational program to inform providers and nursing staff of this requirement and how it will be met. Anticipated start date: April 4, 2011.

Beginning in May, 2011, compliance will be evaluated through chart reviews of identified patients with MDRO colonization/infection. 90% or higher compliance will be achieved by September 30, 2011.

Recommendation 9. We recommended that employees receive annual MDRO education and that the training be consistently documented.

Concur

Target date for completion: September 30, 2011.

This training is tracked on LMS. A local module was created and assigned to clinical employees as an annual training beginning in January, 2011.

Infection Control will monitor and identify services which are not meeting at least a 90% completion rate and work with appropriate Administrative Officers for corrective action.

Recommendation 10. We recommended that written advance directive notification be provided to patients and documented in the medical record.

Concur

Target date for completion: September 30, 2011

Patients will be given written notification about Advance Directives by the nurse who is completing the nursing admission assessment. The form, titled “Your Rights Regarding Advance Directives” will be implemented starting April 15, 2011.

The nursing admission assessment template will be modified to include a written statement confirming written notification was provided to the patient by the nurse

completing the admission assessment. An audit of inpatient admissions will be conducted monthly, times 2 quarters, beginning in April, 2011 to achieve 100% compliance with Advance Directive notification documentation. Based on Joint Commission recommendations 10% of admissions will be audited for Advance Directive compliance.

Recommendation 11. We recommended that pharmacy staff wear clean inner gloves when labeling and placing the chemotherapy infusion into the transport bag.

Concur

Target date for completion: Consider this closed.

Pharmacy staff is now removing the outer gloves prior to labeling and placing the chemotherapy infusion in the transport bag. Education to pharmacy staff regarding proper removal of gloves prior to labeling was completed February 10, 2011. Compliance has been monitored by the pharmacy supervisor on a weekly basis beginning February, 2011 for 2 weeks with a 100% compliance rate. Compliance monitoring will continue on a monthly basis in March and April in order to achieve 100% compliance.

OIG Contact and Staff Acknowledgments

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House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: Dennis Cardoza, Jeff Denham, Anna G. Eshoo, Sam Farr, John Garamendi, Mike Honda, Zoe Lofgren, Jerry McNerney, Jackie Speier, Fortney Pete Stark

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