Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02994-103

Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

February 24, 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
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

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
CRC	Cardiopulmonary Resuscitation Committee
CSC	Clinical Safety Committee
CWAD	Crisis, Warning, Allergies and/or Adverse Reactions, and Directives
EOC	environment of care
facility	John J. Pershing VA Medical Center
FMS	Facility Management Services
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
MDRO	multidrug-resistant organisms
MH	mental health
MSDS	material safety data sheet
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PC	primary care
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RCA	root cause analysis
SOPs	standard operating procedures
UC	urgent care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO

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 November 15, 2010.

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

- Physician Credentialing and Privileging
- Medication Management

The facility's reported accomplishments were reduced readmission rates for mental health patients, reduced fee based care expenditures, and enhanced veterans outreach programs.

Recommendations: We made recommendations in the following five activities:

Management of Test Results: Clearly define critical radiological results requiring prompt provider notification, monitor documentation of communication of critical radiology results to providers and patients, and consistently communicate normal radiological results to patients within the specified timeframe.

Quality Management: Review current medications and drug allergies prior to procedures requiring moderate sedation, and monitor compliance. Review resuscitation events for performance improvement opportunities.

Coordination of Care: Conduct and document screening for advance directives at admission, and monitor compliance. Document advance care planning using approved progress note titles, and monitor compliance.

Environment of Care: Analyze infection control data, and report performance improvement actions to the appropriate committee. Complete and document annual N95 respirator fit testing and bloodborne pathogens training.

Management of Multidrug-Resistant Organisms: Ensure employees receive annual multidrug-resistant organisms education, and document the training.

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 2009, FY 2010, and FY 2011 through November 15, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri,* Report No. 07-02837-83,

February 26, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings to 95 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

Reduced Readmission Rates for MH Patients

The facility implemented a tele-discharge planning process for the discharge of their MH patients from the St. Louis VA Medical Center MH inpatient unit. More than 150 patients have been discharged using this new process. As a result, readmission rates for MH patients fell from 11.76 percent in January 2010 to 6.67 percent in July 2010. The VA Office of Rural Health identified this process, which is a collaborative effort and the first of its kind in the VISN, as a best practice.

Reduced Fee Based Care Expenditures

During FY 2010, the facility reduced its fee based care costs by 25 percent even though its service area is a highly rural environment. The facility also implemented a sleep study center that will significantly reduce costs for this service. The sleep study center alone will result in $1.1 million annual cost savings and will improve wait times for this service. This is expected to significantly improve patient satisfaction in this area.

Enhanced Veterans Outreach

During FY 2010, facility leadership joined the Greater St. Louis Federal Executive Board and greatly expanded its outreach programs by participating in more than 50 local events. The facility developed and implemented new marketing and communication tools and gave formal presentations to the local Rotary Club, Kiwanis Club, and Chamber of Commerce. As a result, there were 1,873 unique patients enrolled in FY 2010, and the facility's market penetration rate increased to 45 percent, one of the highest in the country. The facility also expanded outreach to women veterans by participating in at least 20 women's health events in FY 2010.

The Help Hospitalized Veterans program selected the facility to host a *Valentines for Veterans* concert. Of the 17 sites selected, the facility was the only small rural facility to participate in the event. More than 3,000 veterans and their families were expected to attend at no charge.

Results

Review Activities With Recommendations

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.[1]

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

Identification of Critical Radiology Results. For radiology test results, VA hospitals must define a critical result diagnostic code that is set by the radiologist at the time of report verification.[2] The facility's radiology software program did not include a critical result diagnostic code. Therefore, radiologists coded both critical results that required immediate attention and results that were abnormal but did not require immediate attention as "abnormal, attention needed." To clarify the "abnormal, attention needed" diagnostic code, we reviewed the facility's *Abnormal Radiological Findings* policy, which mandates prompt notification of abnormal "panic values" to the ordering physician. However, the policy did not clearly distinguish between critical results that would require prompt notification and abnormal results that would not require prompt notification. We were unable to fully evaluate the communication of critical radiology results because we were unable to distinguish true critical results from abnormal results.

Monitoring Results Communication. VHA requires facilities to monitor the effectiveness of communication of tests results to providers and patients.[3] We determined that the

[1] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[2] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Sec. 3.3, Communication of Results.
[3] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

laboratory had established an effective process for monitoring communication of laboratory results to ordering providers. However, we did not find evidence that communication of radiology test results to providers and patients was periodically monitored.

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.[4] We reviewed the medical records of 10 patients who had normal radiology results and found that only 8 (80 percent) of the 10 records contained documented evidence that the facility had communicated the results to the patients.

Recommendations

1. We recommended that the facility clearly define critical radiological results that require prompt notification of the ordering provider.

2. We recommended that the facility monitor documentation of communication of critical radiology results to providers and patients.

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

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.

Moderate Sedation. VHA requires providers to document a complete history and physical within 30 days of a procedure and to re-evaluate the patient immediately prior to sedation.[5] These evaluations must include a review of drug allergies and current medications. We reviewed outpatient histories and physical examinations for a selection of procedures where moderate sedation was used and found that only

[4] VHA Directive 2009-019.
[5] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

4 (40 percent) of 10 medical records contained current medications and drug allergy information.

Resuscitation Outcomes. VHA requires that each facility have a policy mandating the membership and responsibilities of a CRC or its equivalent.[6] This committee is responsible for review of individual cardiopulmonary arrests occurring at the facility as well as oversight review of aggregate data to identify and address any trends. While the Clinical Practice Council reviewed aggregate data for FY 2010, we found that the facility did not have a policy or a multidisciplinary committee to analyze each resuscitation event. During our onsite review, the facility revised the Code Blue Team policy and Clinical Patient Safety Committee charter to designate an equivalent CRC.

Recommendations

4. We recommended that current medications and drug allergies be reviewed prior to procedures requiring moderate sedation and that supervisors monitor for compliance.

5. We recommended that each resuscitation event be reviewed by the designated CRC for PI opportunities.

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 areas that needed improvement.

Screening. VHA requires that at the time of each admission to a VHA inpatient facility, patients must be asked whether they have an advance directive or whether they want more information about advance directives and/or assistance in completing the advance directive forms.[7] This screening must be documented in the patient's health record. We found evidence of screening in initial nursing assessments for 17 (85 percent) of the 20 patient records we reviewed.

Advance Care Planning Progress Note Titles. VHA requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link

[6] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[7] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

these notes to the CWAD posting in the electronic medical record.[8] We reviewed advance care planning documentation for 16 patients and determined that the facility used the required progress note titles in 11 (69 percent) of the 16 records. All notes were linked to the CWAD posting. The facility's advance care planning policy had not been updated since the publication of VHA Directive 1004.02 and did not address the specific progress note titles. Senior leadership told us that the local policy was scheduled for review in December and assured us that revisions would address all required components.

Recommendations

6. We recommended that screening regarding advance directives be conducted and documented at each inpatient admission and that supervisors monitor for compliance.

7. We recommended that advance care planning be documented using approved progress note titles and that supervisors monitor for compliance.

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.

We inspected the CLC; the inpatient medical unit; the dental, MH, and wound clinics; a PC/specialty clinic; Radiology Service; the UC area; and the outpatient laboratory and found that the facility maintained a generally clean and safe environment.

We found that the MSDS inventory log in the UC area was outdated. While we were onsite, managers updated the MSDS inventory log.

The JC and the NFPA require at least 18 inches of open space from the sprinkler deflector to the top of a storage unit. In the UC medication room, we found a shelf full of supplies located less than 18 inches below the sprinkler deflector. Managers removed the supplies immediately. Since these conditions were corrected while we were onsite, we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

IC. The JC requires that IC data be analyzed and that actions be prioritized, implemented, and reported. We reviewed IC Committee minutes for the 3rd and 4th quarter of

[8] VHA Handbook 1004.02.

FY 2010 and found that IC monitors were not analyzed for PI.

OSHA requires that facilities using N95 respirators fit test designated employees annually. We reviewed the records of 29 selected employees and determined that only 4 (14 percent) of the 29 employees had the required annual fit testing.

OSHA requires that all employees receive initial and annual training on the OSHA Bloodborne Pathogens Rule. We reviewed training records for 26 selected employees and found that 22 (85 percent) of the 26 employees had this training documented for FY 2010.

Recommendations

8. We recommended that the IC program be strengthened to ensure that data is analyzed and that PI actions are reported to the appropriate committee.

9. We recommended that annual N95 respirator fit testing and bloodborne pathogens training be completed and documented.

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 CLC unit and interviewed employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Employee Training. The JC requires that facilities conduct a risk assessment to determine the need for staff education. The facility's most recent risk assessment and the local IC policy stated that staff education was indicated for all employees during orientation and annually thereafter. We reviewed 35 employee training records to determine whether MDRO education had been completed. We found that 4 (33 percent) of 12 clinical staff and 6 (26 percent) of 23 FMS employees had no documentation of annual MDRO education.

Recommendation

10. We recommended that employees receive annual MDRO education and that the training be documented.

Review Activities Without Recommendations

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 10 physicians' C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

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 interviewed the Chief of Pharmacy and one registered nurse qualified to administer chemotherapy medications. We also reviewed the facility's policy for handling chemotherapy medications. The facility did not have a patient on chemotherapy during our site visit; however, employees correctly described the steps for the preparation, transportation, and administration of chemotherapy medications. 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 13–18, for the full text of the Directors' comments.) We consider Recommendations 1 and 7 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[9]		
Type of Organization	Primary care veteran's rural access to health care	
Complexity Level	3	
VISN	15	
CBOCs	Cape Girardeau, MO Farmington, MO Sikeston, MO Salem, MO West Plains, MO Paragould, AR	
Veteran Population in Catchment Area	50,000	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	18	
• **CLC/Nursing Home Care Unit**	40	
• **Other**	0	
Medical School Affiliation(s)	None	
• **Number of Residents**	0	
	FY 2010 (through August 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$68.9	$63.8
• **Medical Care Expenditures**	$68.9	$63.8
Total Medical Care FTE	363	359
Workload:		
• **Number of Station Level Unique Patients**	18,826	17,975
• **Inpatient Days of Care:**		
o **Acute Care**	4,874	5,132
o **CLC/Nursing Home Care Unit**	8,695	10,133
Hospital Discharges	1,367 medical 153 CLC	1,398 medical 156 CLC
Total Average Daily Census (including all bed types)	40.5	41.2
Cumulative Occupancy Rate	69.9%	71.1%
Outpatient Visits	165,497	146,586

[9] 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. Complete peer reviews within 120 days, and submit quarterly reports to the Medical Executive Committee.	Peer reviews have been completed within required timeframes, and quarterly reports were submitted as required.	Y	N
2. Ensure RCAs are completed within 45 days.	All RCAs have been completed within 45 days for FYs 2009–2010.	Y	N
3. Ensure that the PI Committee serves as oversight for all QM activities.	The Executive PI Committee (formerly the PI Committee) oversees all QM activities.	Y	N
Business Rules			
4. Update business rules to comply with VHA policy.	Business rules comply with VHA policy.	Y	N

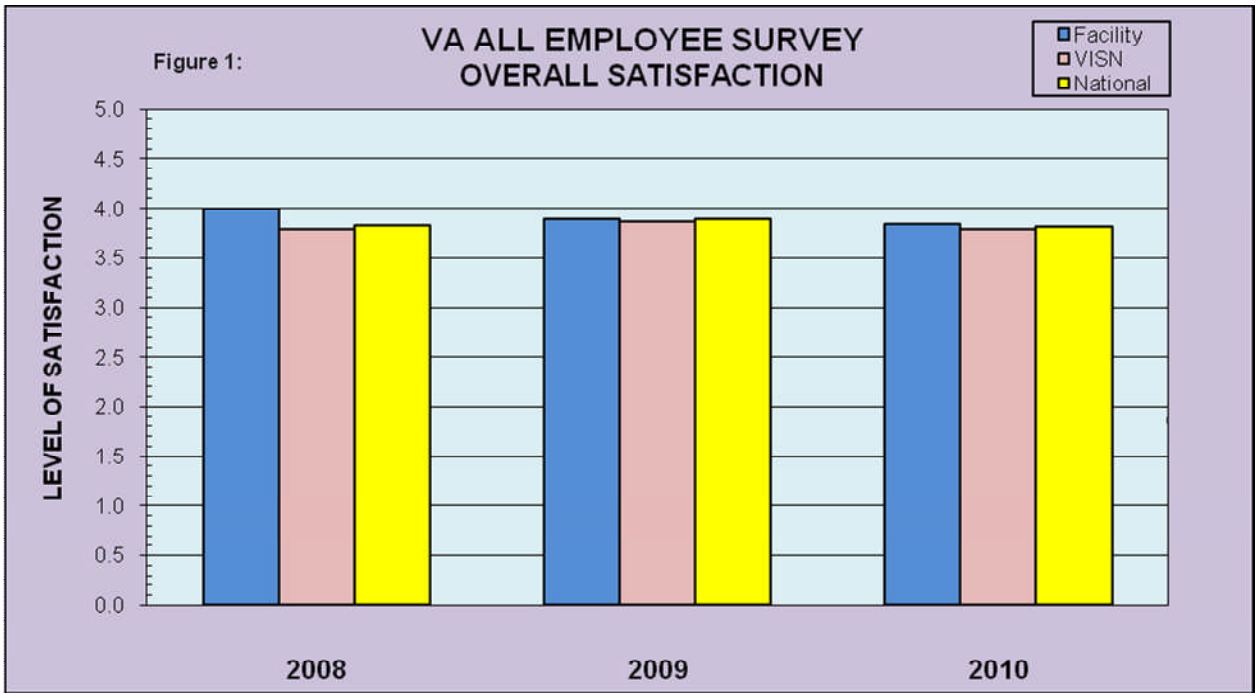
VHA Satisfaction Surveys

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 quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	59.5	60.7	58.0	51.7	48.0	41.5
VISN	59.0	56.0	56.9	53.5	52.9	51.6
VHA	63.3	63.9	64.5	54.7	55.2	54.8

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[10] 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	13.99	11.92	15.08	20.25	20.96	17.29
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[10] 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: February 3, 2011

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, Bay Pines Healthcare Inspections Division (54SP)

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

I have reviewed and concur with the Medical Center Director's response and action plan.

(original signed by:)
JAMES R. FLOYD, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 1, 2011

From: Director, John J. Pershing VA Medical Center (657A4/00)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, VA Heartland Network (10N15)

1. We appreciate the opportunity to review the draft report for the John J. Pershing VA Medical Center in Poplar Bluff, Missouri.

2. Attached, please find Poplar Bluff VA Medical Center's response to the Office of Inspector General Combined Assessment Program (OIG-CAP) review conducted during the week of November 15, 2010.

3. We would like to extend our appreciation to the Office of Inspector General Team that conducted the review; they were very professional and provided excellent feedback to our staff. We appreciate their thorough review and the opportunity to further improve the quality care we provide to our Veterans every day.

4. If you have any questions regarding the information provided, please contact Dawna Bader, Director of Performance Improvement. Ms. Bader can be reached at (573) 778-4280.

(original signed by:)
GLENN A. COSTIE, FACHE
Medical Center 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 facility clearly define critical radiological results that require prompt notification of the ordering provider.

Facility Response: Concur with recommendation.

Target Completion Date: Completed January 26, 2011.

The facility revised its policy on reporting abnormal radiological test results to clearly define critical radiological results. The policy is being circulated for concurrences, and the identification and reporting of critical results have already been put into place according to the new policy's guidance. Recommend closure of this item.

Recommendation 2. We recommended that the facility monitor documentation of communication of critical radiology results to providers and patients.

Facility Response: Concur with recommendation.

Target Completion Date: June 30, 2011.

The facility revised its policy on reporting abnormal radiological test results to clearly define critical radiological results and to outline the process for monitoring communication of critical results. Monitoring of critical radiological results began on January 25, 2011. Results from this monitor will be aggregated, analyzed, and reported to the CSC on a monthly basis in order to identify opportunities for improvement, and will be reduced to quarterly once the target of 90 percent is achieved and sustained.

Recommendation 3. We recommended that normal radiology test results be consistently communicated to patients within the specified timeframe.

Facility Response: Concur with recommendation.

Target Completion Date: March 31, 2011

A new process was implemented in December 2010 in a PC test clinic whereby a PC team member (clerk or licensed practical nurse) is notified by view alert to the normal laboratory and radiology results. Once the alert is received, the PC team member initiates and sends a letter on behalf of the patient's PC Provider notifying the veteran of his/her normal test results and documents this action in the electronic health record. So far, this process has been effective in the test clinic and will be rolled out to the remaining PC clinics by March 31, 2011. Afterwards, a monthly chart review will be

performed for every clinic and results reported through the Medical Records Committee until the target of 90 percent is achieved and sustained, after which the review will be conducted quarterly.

Recommendation 4. We recommended that current medications and drug allergies be reviewed prior to procedures requiring moderate sedation and that supervisors monitor for compliance.

Facility Response: Concur with recommendation.

Target Completion Date: June 30, 2011.

The facility revised its Licensed Independent Practitioner (LIP) pre-operative assessment template to include a required field for review of medications and allergies. The facility also revised its concurrent medical record review tool to include a section on documentation of medication and allergy review prior to administration of moderate sedation. This concurrent tool is used to review 100 percent of endoscopy cases. Staff began using the revised tool on February 1, 2011. Results from the concurrent review will be reported through the Surgical Quality Improvement Committee on a monthly basis in order to identify opportunities for improvement until the target of 90 percent is achieved and sustained, after which the review will be conducted quarterly.

Recommendation 5. We recommended that each resuscitation event be reviewed by the designated CRC for PI opportunities.

Facility Response: Concur with recommendation.

Target Completion Date: Completed November 23, 2010.

On November 16, 2010, the CSC charter was revised to include its delegated responsibility to act as the facility's CRC. The CSC began quarterly case review of each individual resuscitation event with the first discussion occurring on November 23, 2010. In addition to this action, all cardiopulmonary resuscitation cases are reviewed and discussed in either the Morbidity and Mortality Committee or the Peer Review Committee as has been the practice for a number of years. Recommend closure of this item.

Recommendation 6. We recommended that screening regarding advance directives be conducted and documented at each inpatient admission and that supervisors monitor for compliance.

Facility Response: Concur with recommendation.

Target Completion Date: June 30, 2011.

Advance Directives (AD) screening and education is performed as part of the inpatient admission assessment and is monitored as part of the quarterly ongoing medical record review process. Due to the underperforming results, the supervisor provided education

to Acute Care staff, and a random sample of medical records are being reviewed on a monthly basis to determine if AD screening and education was performed as required. Findings from this review will be reported to the Medical Record Committee until a target of 90 percent compliance is achieved and sustained, after which it will be moved to a quarterly monitor.

Recommendation 7. We recommended that advance care planning be documented using approved progress note titles and that supervisors monitor for compliance.

Facility Response: Concur with recommendation.

Target Completion Date: Completed January 28, 2011.

The VHA allows only three progress note titles for advance directives: Advance Directives, Advance Directive Discussions, and Rescinded Advance Directives. Because the facility is part of an integrated computer system with two other VA facilities, we could not incorporate a documentation template using these three notes, and a fourth progress note title, "Advance Directives – PB" was instituted, which allowed the incorporation of a documentation template. As a result of the OIG's recommendation, on January 28, 2011, the progress note title "Advance Directives – PB" was inactivated and only the three allowed progress notes titles remain. Compliance with using only the allowed progress notes titles will be monitored as part of the ongoing medical record review (refer to facility response to recommendation 6). Since no other progress note title is available to staff, recommend closure of this item.

Recommendation 8. We recommended that the IC program be strengthened to ensure that data is analyzed and that PI actions are reported to the appropriate committee.

Facility Response: Concur with recommendation.

Target Completion Date: Completed December 28, 2010.

In October 2010, a new committee, the CSC, was formed, which was delegated to serve as the facility's IC Committee. IC results and data analysis are presented on a monthly basis by the IC Nurse and the IC Physician, and the reports are submitted to the CSC who reviews the reports to identify opportunities for improvement. Recommend closure of this item.

Recommendation 9. We recommended that annual N95 respirator fit testing and bloodborne pathogens training be completed and documented.

Facility Response: Concur with recommendation.

Target Completion Date: Fit-Testing will be completed by April 30, 2011. Training on Blood-borne Pathogens will be completed by September 30, 2011.

A risk assessment identified 100 employees who need to be fit-tested for N-95 face masks according to the facility's TB and IC Plans. The facility recently hired a full-time GEMS Coordinator who is an Industrial Hygienist and an OSHA Certified Fit Tester, and he will perform fit testing for all 100 N-95 users by April 30, 2011, and annually thereafter. Blood-borne Pathogens training is an annual training requirement for all staff, and is documented and tracked in LMS. The Education Department will run monthly reports by service and submit them to unit supervisors and service chiefs until 100 percent compliance is achieved. These reports will also be submitted to the EOC Committee, who will track employee compliance in completing N-95 Fit Testing, and to the CSC (the facility's IC Committee) who will track employee completion of Blood-borne Pathogens.

Recommendation 10. We recommended that employees receive annual MDRO education and that the training be documented.

Facility Response: Concur with recommendation.

Target Completion Date: September 30, 2011.

A presentation on Multiple Drug Resistant Organisms (MDRO) was developed and made available to staff on February 1, 2011. It will be completed by all staff (excluding administrative staff) and as part of new employee orientation beginning February 1, 2011, with required annual retraining for the same target employee group. Completion of MDRO training will be documented and tracked in LMS and reported by the IC Nurse on a monthly basis until the target of 95 percent is achieved and sustained.

OIG Contact and Staff Acknowledgments

Contact	Christa Sisterhen, Director Bay Pines Office of Healthcare Inspections
Contributors	David Griffith, Team Leader Bettye Burns Darlene Conde-Nadeau Kathy Gudgell Alice Morales-Rullan Annette Robinson Carol Torczon Idell Graham James Werner, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Heartland Network (10N15)
Director, John J. Pershing VA Medical Center (657A4/00)

Non-VA Distribution

House Committee on Veterans' Affairs
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: Roy Blunt, John Boozman, Claire McCaskill, Mark L. Pryor
U.S. House of Representatives: Rick Crawford, Jo Ann Emerson

This report is available at http://www.va.gov/oig/publications/reports-list.asp.