Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01298-268

Combined Assessment Program Review of the Wilkes-Barre VA Medical Center Wilkes-Barre, Pennsylvania

September 1, 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.

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
EN	enteral nutrition
EOC	environment of care
facility	Wilkes-Barre VA Medical Center
FY	fiscal year
OIG	Office of Inspector General
PR	peer review
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA

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 May 9, 2011.

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

- Enteral Nutrition Safety
- Management of Workplace Violence
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishments were the institution of a daily suicide prevention meeting and the development of an automated policy tracking system to ensure timely completion of new facility policies.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Correct identified infection prevention and cleanliness deficiencies. Ensure that all open medications are labeled with expiration dates and that all required team members consistently attend environment of care rounds.

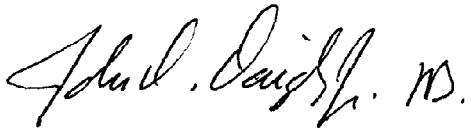
Registered Nurse Competencies: Ensure that competency documents contain all required signatures and dates.

Quality Management: Ensure that moderate sedation documentation includes all required elements and that supervisors monitor compliance. Require the Director to approve all peer review extensions in writing.

Coordination of Care: Ensure that advance directive screening is accurate and that patients' hard copy advance directives are scanned into the electronic medical record.

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.



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 eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Work Place Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through May 9, 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 Wilkes-Barre VA Medical Center,*

Wilkes-Barre, Pennsylvania, Report No. 07-03445-97, March 17, 2008). (See Appendix B for further details) The facility had a repeat finding in the area of EOC rounds.

During this review, we also presented crime awareness briefings for 186 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

Suicide Prevention Daily Meeting

Individuals with key responsibilities for the prevention and management of veterans at high risk for suicide meet daily with the Suicide Prevention Coordinator. They discuss all contacts with veterans at high risk for suicide during the past 24 hours and ensure the safety of these veterans by instituting all possible interventions. In addition, the meeting serves as a mechanism to identify process issues and barriers that impede efficient and effective services. The information discussed is communicated to the facility's Director daily.

Automated Medical Center Policy Tracking

The Automated Medical Center Policy Concurrence Process was developed using SharePoint. Once a policy is developed, it is uploaded to the site and automatically routed for concurrence. All responses and delinquencies are tracked. Once the policy is finalized, an automated message is sent to all facility employees notifying them of the new policy. In addition, the system fosters excellent coordination and communication between services and leadership, allows for efficient policy searches, and improves team productivity. This green initiative allows information to be compiled as one document and reduces the need for multiple e-mails and hard copies.

Results

Review Activities With 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.

We inspected the locked mental health, intensive care/telemetry, community living center, medical/surgical, post-anesthesia care, and special procedures units. We also inspected the emergency department and the dental and eye clinics. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Prevention and Cleanliness. The Joint Commission requires that facilities reduce the risk of infections associated with the storage of medical equipment, devices, and supplies. Local policy requires that wheelchairs have a colored tag with the cleaning date attached to the back of each chair. We found equipment and supplies that were not clearly marked as clean stored in clean utility rooms, suction devices that were unpackaged at unoccupied bedsides, and low-lying shelving that did not allow for proper cleaning of the floor under the shelves. Additionally, we found many wheelchairs stored in the emergency department that were ready for patient use but were not properly tagged.

Medication Safety and Security. The Joint Commission requires that opened medications be labeled with expiration dates. On two units, we found open medication vials that were not labeled with expiration dates.

EOC Rounds. VHA policy requires the Director or the Associate Director to lead weekly EOC rounds.[1] Participants should include managers in nursing, building management, engineering, safety, patient safety, infection control, information security, and others as required. We found that required team members' attendance at these rounds has been inconsistent. This was a repeat finding from the previous CAP review.

Recommendations

1. We recommended that the identified infection prevention and cleanliness deficiencies be corrected.

2. We recommended that processes be strengthened to ensure that all open medications are labeled with expiration dates.

3. We recommended that all required EOC team members consistently attend EOC rounds.

[1] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse leaders, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. Local policy requires that both the employee and supervisor sign the competency document. In addition, the supervisor must sign and date each item in the document. Nine out of the 12 RN competency folders reviewed had missing signatures and/or incomplete or missing dates.

Recommendation

4. We recommended that processes be strengthened to ensure that competency documents contain all required signatures and dates.

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 policy requires facilities to document patient assessment prior to use of moderate sedation.[2] We reviewed the medical records of 10 patients who had selected procedures where moderate sedation was used and found that 6 of the records had missing elements. Missing elements included airway assessment, review of organ systems, and assessment of risk.

PR. VHA policy requires written approval by the facility's Director for an extension on any PR that will exceed the 120-day deadline for completion.[3] For FY 2010 and the 1st quarter of FY 2011, we found four PRs that were not completed within 120 days, and none had the Director's written approval for an extension.

[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

Recommendations

5. We recommended that moderate sedation documentation include all required elements and that supervisors monitor compliance.

6. We recommended that the Director approve all PR extensions in writing.

Coordination of Care

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

We reviewed patients' medical records for evidence of advance directive notification, advance directive screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following area that needed improvement.

Advance Directive Screening Accuracy. VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an advance directive and document the screening in the medical record. If a patient reports having an advance directive, staff should attempt to obtain the document and scan it into the electronic medical record. We found that screening was inaccurate in 5 of the 20 patient medical records reviewed. One screening documented that there was no advance directive; however, we located an advance directive in the electronic medical record. Four screenings documented the presence of an advance directive; however, we could not locate one in the medical record, and there was no note requesting that the patient provide a copy to the facility.

Recommendation

7. We recommended that processes be strengthened to ensure that advance directive screening is accurate and that patients' hard copy advance directives are scanned into the electronic medical record.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the

facility generally met EN safety requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Although the facility did not have any incidents of assault in the past 2 years, it did have a comprehensive workplace violence policy. The training plan addressed the required prevention and management of disruptive behavior training. 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 observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no 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 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.

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 12–18, for the full text of the Directors' comments.) We consider Recommendations 2 and 6 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[4]		
Type of Organization	Teaching hospital that provides primary and tertiary services	
Complexity Level	2	
VISN	4	
Community Based Outpatient Clinics	Allentown, PA Sayre, PA Williamsport, PA Tobyhanna, PA Berwick, PA Bangor, PA	
Veteran Population in Catchment Area	173,296 (Projected for FY 2011)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	68	
• **Community Living Center/Nursing Home Care Unit**	105	
• **Other**	N/A	
Medical School Affiliation(s)	The Commonwealth Medical College	
• **Number of Residents**	5	
	FY 2011 (through December 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$215.2	$210.7
• **Medical Care Expenditures**	$60.1	$210.1
Total Medical Care Full-Time Employee Equivalents	1,107.4	1,125.1
Workload:		
• **Number of Station Level Unique Patients**	26,818	40,615
• **Inpatient Days of Care:**		
o **Acute Care**	4,632	14,700
o **Community Living Center/Nursing Home Care Unit**	5,829	28,179
Hospital Discharges	786	3,373
Total Average Daily Census (including all bed types)	114	122
Cumulative Occupancy Rate (in percent)	65.7	70.8
Outpatient Visits	91,036	381,717

[4] 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**
EOC			
1. Comply with VHA patient safety standards for inspections of locked mental health units.	Semi-annual inspections of locked mental health units are conducted using the VHA mental health EOC checklist. All deficiencies are addressed and tracked to resolution.	Y	N
2. Reassess the number of individuals needed to participate in annual respirator fit testing to support current infectious disease programs.	Facility converted to 100 percent Helmet powered air-purifying respirator use. No annual fit test required.	Y	N
3. Ensure designated EOC team members participate in all EOC rounds and that community based outpatient clinics are inspected semi-annually.	Per facility policy, all designated EOC inspection team members are required to participate in EOC rounds and inspect community based outpatient clinics semi-annually.	Partially	Y
4. Lock dirty utility rooms.	Dirty utility rooms are required to be locked at all times. Doors have mechanical closers and lock automatically. Compliance with this requirement is checked bi-annually during EOC rounds.	Y	N
QM			
5. Ensure the PR Committee documents discussion of recommendations for improvement in patient care and analyzes trends and findings.	PR Committee minutes include discussion of system issues requiring improvement and analysis of trends identified.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Improve processing times for root cause analyses, and implement a central QM database to track action items to completion.	All root cause analyses are completed within the 45-day timeframe. All root cause analyses actions/outcome measures are tracked using a central database until completion.	Y	N
Survey of Healthcare Experiences of Patients			
7. Develop and implement an action plan for improvement of patient satisfaction based on Survey of Healthcare Experiences of Patients data results.	Customer service training is provided at new employee and annual training. Survey of Healthcare Experiences of Patients and Hospital Consumer Assessment of Health Providers and Systems data is briefed to the Performance Improvement and QM Committees and to service line managers, who share the information with their staff.	Y	N

VHA Satisfaction Surveys

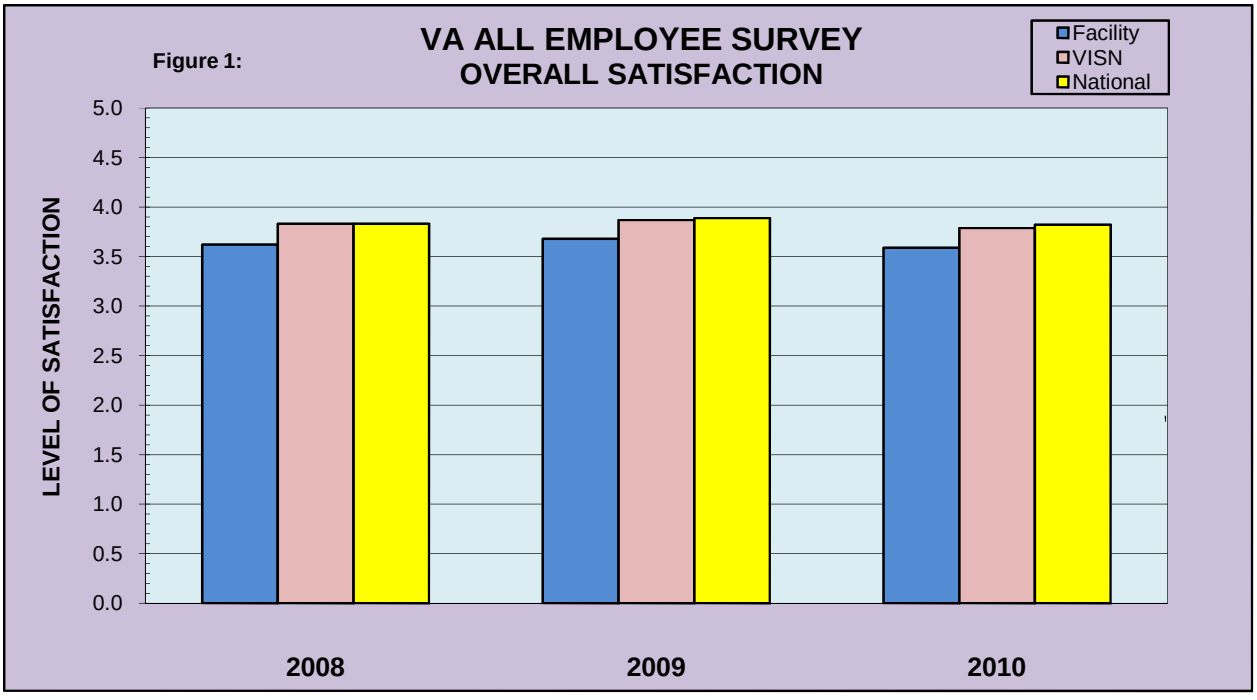
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

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	62.2	63.8	68.3	69.5	61.8	58.1	61.8	60.0
VISN	62.7	65.5	65.3	63.0	59.5	61.4	60.1	61.8
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[5] 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	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	13.50	10.57	19.06	20.49	22.67	17.07
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[5] Congestive heart failure 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: August 5, 2011

From: Director, VA Healthcare Network, VISN 4 (10N4)

Subject: **CAP Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed the draft report of the Wilkes-Barre VA Medical Center. I concur with the findings and implemented plans.

(original signed by:)
MICHAEL A. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 1, 2011

From: Director, Wilkes-Barre VA Medical Center (693/00**)**

Subject: **CAP Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Director, VA Healthcare Network, VISN 4

Attached are comments submitted in response to the recommendations in the Draft Office of Inspector General Report.

(original signed by:)
William H. Mills

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 identified infection prevention and cleanliness deficiencies be corrected.

Concur

Each deficiency in Recommendation 1 is addressed as a separate numbered issue in Facility Response below.

Target dates for completion:

05/11/2011 #1a **Completed**; 06/30/2011 #1b **Completed**; 03/31/2012 #1c & #1d.

05/13/2011 #2a, #2b, #2c, #2d **Completed**.

05/11/2011 #3a **Completed**; 05/17/2011 #3b **Completed**; 11/30/2011 #3c.

05/11/2011 #4a and #4b **Completed**; 11/30/2011 #4c.

05/27/2011 #5a **Completed**; 10/01/2011 #5b.

Facility Response:

Issue #1: Wheelchairs stored in Emergency area were not properly tagged to indicate that cleaning was done.

a. Wheelchairs at ED entrance were cleaned and tagged according to local process on May 11, 2011.
b. Environmental Management Service (EMS) supervisors and staff were reminded to adhere to the specified procedure for cleaning and tagging wheelchairs.
c. Refresher training is conducted quarterly (June, September, December and March) to achieve 100% of EMS staff on the separation of clean vs. dirty equipment.
d. Documentation of training will be maintained in EMS office.

Issue #2: IV pumps and poles located in ED were not identified as having been cleaned between patient use.

a. SPD staff provided cleaned IV pumps to the ED area on May 11, 2011.

b. May 12, 2011, ED staffs were instructed to place used IV pumps in the soiled utility room after use.
c. May 13, 2011, all nursing staff in all areas were instructed to place used IV pumps in the soiled utility rooms after use.
d. On a daily basis, SPD staff clean the IV pumps/poles placed in the soiled utility rooms throughout the facility. Clean IV pumps are bagged and tagged with date prior to being placed in the clean storage areas.

Issue #3: Equipment not clearly marked as clean was stored in clean utility rooms.

a. The equipment in question was removed immediately. Item was cleaned, bagged and tagged prior to return to the clean room on May 11, 2011.
b. Nursing staff was educated on the process of bagging and tagging all cleaned equipment for the ED on May 17, 2011.
c. The ED Nurse Manager monitors the clean room and reports audits monthly to Deputy Nurse Executive for four consecutive months.

Issue #4: Suction devices were not unpackaged at unoccupied bedsides.

a. Unpackaged suction devices were immediately removed from the area on May 11, 2011.
b. All PACU/OR staff was educated on the proper storage of the suction devices at time of observation, May 11, 2011.
c. OR Nurse Manager monitors the PACU daily for four consecutive months, to insure compliance with having the set up for emergency suctioning bagged and tagged to keep clean until use.

Issue #5: Low-lying shelving units that did not allow for proper cleaning of floor under the shelves.

a. Short Term Resolution: In all clinical areas, all items on the low-lying shelf have been removed and signage placed on this shelf stating “DO NOT USE BOTTOM SHELF.”
b. Long Term Resolution: All existing shelving units will be evaluated for complete removal of bottom shelf which will allow for proper cleaning. Those shelving units that cannot be modified will be replaced with mobile wire shelving units with appropriate 8 inch clearance on a solid bottom shelf.

Recommendation 2. We recommended that processes be strengthened to ensure that all open medications are labeled with expiration dates.

Concur

Target date for completion: 08/04/2011

Facility Response:

The open medication vial was immediately discarded.

In order to strengthen the process to ensure that all open medication vials are labeled with expiration dates, the following will take place:

1. Nursing staff will place label on vials when opened. Label will include expiration date. (Pharmacy will continue to label high alert multi-dose vials.)
2. Nurse Managers on each unit will monitor vials/labels monthly as a part of EOC rounds.

Recommendation 3. We recommended that all required EOC team members consistently attend EOC rounds.

Concur

Target date for completion: 05/19/2011 **Completed**.

Facility Response:

Attendance was addressed immediately following the OIG-CAP Visit. The Associate Medical Center Director, or designee, has led all EOC Rounds from May through July, 2011. Attendance at EOC Rounds was discussed with all involved parties and an EOC Mail Group has been established for routine notification of all committee members. Messages are sent to the Committee Members, via the EOC Mail Group, on the morning of the rounds, noting time, location and a reminder that attendance is mandatory.

EOC Rounds' attendance has significantly improved with the implementation of the verbal and written reminders. Since May, 2011, attendance has improved to an averaged 96.3%. With the continuation of reminder notices, attendance is anticipated to remain steady.

Recommendation 4. We recommended that processes be strengthened to ensure that competency documents contain all required signatures and dates.

Concur

Each deficiency in Recommendation 4 is addressed as a separate numbered issue in Facility Response below.

Target date for completion: 08/04/2011 (#1, #2, and #3) and 11/30/2011 (#4).

Facility Response:

The 3 competency files with missing signatures and dates were immediately corrected and placed in employee personnel file.

In order to strengthen the process to ensure competency documents contain all required signatures and dates, the following action will take place:

1. Nurse Managers will be re-educated on completion of competency forms.
2. Nurse Managers will review competency form prior to submission for Nurse Executive/Deputy Nurse Executive signatures to ensure dates and signatures are present.
3. Nurse Executive/Deputy Nurse Executive will review competency forms for completeness prior to placement in employee files.
4. Random audits will be completed by Patient Support Assistant and Timekeeper for Nursing Service, for four consecutive months.

Recommendation 5. We recommended that moderate sedation documentation include all required elements and that supervisors monitor compliance.

Concur

Each deficiency in Recommendation 5 is addressed as a separate numbered issue in Facility Response below.

Target date for completion: 08/31/2011 (#1, #2, and #3) and 12/31/2011 (#4).

Facility Response:

1. Medical Center policy will be revised to include assessment of airway, review of organ systems and assessment of risk.
2. The moderate sedation template will be amended to include these elements as required fields.
3. Once the policy is approved and the template changed, providers will be educated on the revised requirements.
4. With implementation of changes, the Medical Records Committee will monitor compliance with documentation of assessment of airway, review of organ systems and assessment of risk. Outcomes will be reported as a performance improvement indicator to Surgical Service. Monitoring will be continued until overall monthly sustained compliance is 100% for four consecutive months, following implementation of policy.

Recommendation 6. We recommended that the Director approve all PR extensions in writing.

Concur

Target date for completion: 07/26/11 **Completed**.

Facility Response:

Peer Review Committee has revised 'Request for Extension' letter for Director's signature which was implemented July 26, 2011.

Peer Review Committee created spreadsheet for on-going tracking which was implemented July 26, 2011.

Recommendation 7. We recommended that processes be strengthened to ensure that advance directive screening is accurate and that patients' hard copy advance directives are scanned into the electronic medical record.

Concur

Target date for completion: 08/15/2011(#1 and #2) and 12/31/2011 (#3).

Facility Response:

All patients admitted to the WBVAMC are asked, as part of the initial Nursing Assessment, "*Do you have an Advanced Directive?"* If the answer is yes then the patient is asked to provide a copy of the document. Upon receipt of the document it is sent to Medical Records for scanning into the medical record. A note titled "Advance Directive," is placed in the medical record and the presence of an Advance Directive is included in the Crises, Warnings, Allergies and/or Adverse Reactions and Directives (CWAD) posting section of the medical record.

If the patient indicates that he does not have an advance directive, he is then asked if he would like more information about creating one. If the patient indicates no, then this information is documented in a note titled "*Advance Directive Discussion".*

If the patient indicates he would like more information, or that he/she would like to develop an Advance Directive, then a consult is placed with Social Work Service requesting follow-up. Designated Social Worker will provide patient with requested information and any other assistance necessary. When the discussion results in the patient completing an advance directive, the advance directive must be filed or scanned with a progress note titled "*Advance Directive*." Documentation of the discussion that led to the filing of an advance directive can be in the form of an addendum to the "*Advance Directive*" note associated with that advance directive or in a separate note titled "*Advance Directive Discussion*." The presence of an Advance Directive is included in the Crises, Warnings, Allergies and/or Adverse Reactions and Directives (CWAD) posting section of the medical record.

1. The Chief of Social Work Service ensures that advance directive screenings are accurate and completed by providing education and policy to staff.
2. The Chief of Social Work Service ensures that advance directive documents are scanned into the electronic medical record, by providing education and policy to staff.
3. The Chief of Social Work assures compliance with policy by conducting a record review of all medical center admissions for a four month period beginning on September 11, 2011 and continuing through December 31, 2011.

OIG Contact and Staff Acknowledgments

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