Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03088-138

Combined Assessment Program Review of the G. V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi

June 2, 2009

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 fraud and integrity awareness training 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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Executive Summary

Introduction

During the week of January 26–30, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the G. V. (Sonny) Montgomery VA Medical Center (the medical center), Jackson, MS. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 252 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength and reported accomplishment:

- Patient Safety Program.

We made recommendations in four of the activities reviewed. For these activities, the medical center needed to ensure that:

- Safety plans are completed for patients deemed at high risk for suicide.
- The air ventilation outlets in the community living center (CLC) and on one acute inpatient unit (4CS) are cleaned according to the standard operating procedure.
- The cleanliness of the dialysis unit is maintained.
- The security of the medication room on the post-anesthesia care unit (PACU) is maintained.
- Peer reviews are completed in a timely manner.
- The Peer Review Committee (PRC) fully documents discussions in committee minutes.
- Mechanisms are in place to adequately evaluate and disclose adverse events.
- The effectiveness of pain medication is documented in the electronic medical record within the medical center's required timeframe.

The medical center complied with selected standards in the following four activities:

- Contract/Agency Registered Nurses (RNs).
- Coordination of Care (COC).
- Emergency/Urgent Care Operations.
- Patient Satisfaction.

This report was prepared under the direction of Christa Sisterhen, Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–17, for the full text of the Directors' comments.) 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

Introduction

Profile

Organization. The medical center is a tertiary care facility located in Jackson, MS, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics (CBOCs) in Kosciusko, Greenville, Hattiesburg, Natchez, Meadville, Columbus, and Meridian, MS. The medical center is part of VISN 16 and serves a veteran population of about 132,000 throughout 19 counties in Mississippi and Arkansas.

Programs. The medical center provides medical, surgical, primary care, mental health (MH), long-term care, and rehabilitation services. It has 128 hospital beds and 120 CLC[1] beds.

Affiliations and Research. The medical center is affiliated with 25 colleges, universities, and institutions. It supports training for 338 medical residents and for various other disciplines. In fiscal year (FY) 2008, the medical center research program had 82 projects and a budget of $1 million. Important areas of research included Alzheimer's disease, schizophrenia, and hypertension.

Resources. In FY 2008, medical care expenditures totaled $276 million. FY 2008 staffing was 1,864 full-time employee equivalents (FTE), including 99 physician and 593 nursing FTE.

Workload. In FY 2008, the medical center treated 44,976 unique patients and provided 34,858 inpatient days in the hospital and 37,312 inpatient days in the CLC. The inpatient care workload totaled 5,981 discharges, and the average daily census, including CLC patients, was 197. Outpatient workload totaled 459,786 visits.

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.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and home-like environment to eligible veterans who require a nursing home level of care.

- Provide fraud and integrity awareness training 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Contract/Agency RNs.
- COC.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered medical center operations for FY 2007, FY 2008, and FY 2009 through January 23, 2009, 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 medical center (*Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi,* Report No. 06-01520-211, September 15, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 252 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. Activities in the "Review Activities Without Recommendations" section have no findings that required corrective action.

Organizational Strength

Patient Safety Program

The National Center for Patient Safety (NCPS) recently instituted a new program called the "Cornerstone" program. Its purpose is to enhance the root cause analysis (RCA) process. The "Cornerstone" program recognizes patient safety staff at the medical center level by rewarding VA medical centers for timeliness in completion of the RCA process. Medical centers are required to complete eight RCAs per year. This medical center received the "bronze" award from the NCPS for FY 2008 for completing 20 RCAs within the required 45-day timeframe.

Results

Review Activities With Recommendations

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with Veterans Health Administration (VHA) regulations. We assessed whether senior managers had appointed a Suicide Prevention Coordinator (SPC) at the medical center and at any very large CBOCs,[2] and we evaluated whether the SPC fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[3] documented safety plans that addressed suicidality, and documented collaboration between MH providers and the SPC.

We interviewed the medical center SPC, and we reviewed pertinent policies and the medical records of 12 patients determined to be at risk for suicide. We found that the suicide prevention program was generally effective; however, we identified one area in need of improvement.

[2] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[3] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

Medical Record Review. VHA regulations[4] require that all medical records of patients at high risk for suicide have a Category II PRF and a safety plan and show evidence of collaboration between the SPC and MH providers. We found that the required PRFs were present in all 12 of the records reviewed and that all contained documented evidence of collaboration between the SPC and MH providers. However, only 4 (33 percent) of the 12 records contained evidence of a safety plan.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans for patients deemed at high risk for suicide.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that a process has been implemented to ensure that all patients on the high-risk list have safety plans. The SPC will track documentation and share this information with leadership during morning reports. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center maintained a safe and clean health care environment. VHA medical centers are required to provide a comprehensive EOC program that fully meets VHA, NCPS, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the acute inpatient units on 2A, 4CN, and 4CS; the medical intensive care unit; the surgical intensive care unit (SICU); and the PACU. We also inspected the locked MH unit, the CLC, the dialysis unit, the emergency department (ED), and the primary care clinics. We found that the medical center was generally clean and well maintained and had corrected the EOC findings from our prior CAP review.

The infection control program monitored exposures and reported data to clinicians for implementation of quality improvements. Also, we found that the majority of the hazards on the "Mental Health Environment of Care

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Checklist"[5] had been abated on the locked MH unit, as required by VHA. However, we identified deficiencies related to environmental cleanliness, security of medications, and patient privacy.

We found that video monitor screens used for patient observation at the SICU nursing station could be viewed by anyone on the unit, including visitors. JC standards require hospitals to respect each patient's need for privacy. Managers installed privacy screens on the monitors while we were onsite; therefore, we made no recommendation for this finding.

Environmental Cleanliness. During environmental rounds, we found dust in air ventilation outlets in several bathrooms in the CLC and on one acute inpatient unit (4CS). The medical center had not followed their standard operating procedure for cleaning the air ventilation outlets. The air ventilation outlets in the CLC were cleaned while we were onsite, and medical center managers provided an action plan to clean all the air ventilation outlets on the acute inpatient units.

The dialysis unit preparation room was not clean; there were visible stains and spills on the floor, on trashcans, and in sinks. We were told that Environmental Management Service (EMS) cleaned the unit during the night shift; however, they did not routinely clean it during the day. The unit was thoroughly cleaned while we were onsite, and managers presented us with an action plan that included daily cleaning by EMS during the day shift and additional support whenever needed.

Security of Medications. We found the door to the medication room on the PACU unlocked and propped open. A nurse told us that the door was kept open for immediate access to medications during an emergency. JC standards require that all medications be secured to prevent access by unauthorized individuals. The door was secured while we were onsite, and managers presented us with an action plan to ensure that the security of medications on the PACU is maintained.

[5] A tool used for the purpose of assessing environmental risks and eliminating factors that could contribute to attempted suicide or suicide of a patient or harm to a staff member.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the air ventilation outlets in the CLC and on acute inpatient unit 4CS are cleaned according to the standard operating procedure.

The VISN and Medical Center Directors agreed with the findings and recommendation. The air ventilation outlets were cleaned the day of the finding, and a schedule has been developed for cleaning all air ventilation outlets areas in the medical center. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the cleanliness of the dialysis unit is maintained.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that scheduled cleaning will take place on a daily basis and as needed. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the security of the medication room on the PACU is maintained.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that PACU medication room security will be monitored daily by the nursing supervisor. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management

The purpose of this review was to determine whether: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. We interviewed the medical center's senior management team and QM personnel. We reviewed plans, policies, and other relevant QM documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review

structures were in place for 13 of the 15 program activities reviewed. However, we identified two areas that needed improvement.

Peer Review. We found that the medical center's PRC did not comply with certain aspects of VHA policy.[6] We evaluated peer review activities conducted during FY 2008 and identified the following issues:

- The PRC did not complete all peer reviews within the required timeframes. We noted that 27 (20 percent) of the 133 peer reviews did not meet the initial 45-day deadline and that 21 (16 percent) did not meet the 120-day completion deadline.
- PRC minutes did not contain complete documentation of formal discussions of the cases under review, the issues under consideration, or the process by which members reached consensus regarding the quality of care.

Adverse Event Disclosure. The medical center did not comply with all elements of VHA policy[7] for disclosure of adverse events to patients and/or their families within required timeframes. Clinical disclosure is an informal process which must occur within 24 hours of provider awareness of the event. Institutional disclosure is a more formal process which must occur within 72 hours of provider awareness of the event and is used in cases of serious injury, death, or potential legal liability. Institutional disclosure includes documentation of an apology and compensation information.

The medical center identified 23 events that required disclosure in the 1-year period ending in November 2008. We found that 14 (61 percent) of the 23 events were disclosed within the required timeframes. Also, while onsite, we discovered two cases that had not been identified by the medical center for consideration of disclosure. We met with the Chief of Staff who agreed that clinical disclosure was appropriate for these two cases.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews.

[6] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[7] VHA Directive 2008-002, *Disclosure of Adverse Events*, January 18, 2008.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that a plan has been put in place to ensure completion of peer reviews within the required timeframes. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires full documentation of PRC discussions in committee minutes.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that PRC minutes will now contain full documentation of discussions. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that disclosures are now being performed for all known complications. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether the medical center had safe medication management practices that complied with medical center policy. Medication management includes ordering, administering, and monitoring medications.

We reviewed selected medication management processes on the acute inpatient medical and surgical units, on the telemetry unit, and in the CLC. We randomly selected 20 patients' medical records for documentation of PRN[8] pain medication effectiveness. Our selection included five patients from each of four different inpatient units.

We found adequate management of medications brought into the medical center by patients or their families and appropriate use of patient armbands to correctly identify

[8] PRN medications are administered on an "as needed" basis.

patients prior to medication administration. However, we identified the following area that needed improvement.

Documentation of PRN Effectiveness. The effectiveness of PRN pain medications was not consistently documented in accordance with medical center policy. We reviewed 57 doses of pain medications and found that 18 (32 percent) doses did not have medication effectiveness documented within 4 hours of administration and that 3 (5 percent) doses had no documentation of medication effectiveness.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that the effectiveness of PRN pain medication is documented in the electronic medical record within the medical center's required timeframe.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that actions will be taken to ensure appropriate documentation of the effectiveness of PRN medications. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Contract/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in the medical center through contracts or temporary staffing agencies met the same requirements as RNs hired as part of the medical center's staff. We reviewed eight contract RN files for several required components, including licensure, training, and VHA and medical center specific competencies.

We found that the medical center had appropriate processes in place for hiring and evaluating contract staff and followed them consistently. However, we found discrepancies between two medical center policies and the orientation checklist for documents required for employee files. We suggested that the discrepancies between the policies and the checklist be reconciled so that all contain an accurate list of required documentation. Medical center managers revised the policies and the checklist while we were onsite; therefore, we made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (unit-to-unit) transfers, and discharges were coordinated appropriately over the

continuum of care and met medical center, VHA, and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed inpatient consultations and found that 10 (83 percent) of the 12 were completed within the 24 hours required by medical center policy. Also, we reviewed the medical records of patients who were transferred between inpatient units. In 11 (92 percent) of the 12 records reviewed, we found consistent and timely documentation of nurse-to-nurse communication from the sending unit to receiving unit, and 10 (83 percent) of the 12 records showed appropriate physician-to-physician communication. Additionally, we reviewed 12 medical records of discharged patients and found documentation that all patients received and understood the written discharge instructions. We made no recommendations.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in the medical center's ED, including clinical services, consultations, inter-facility transfers, staffing, and staff competencies. We also assessed the ED's physical environment and equipment maintenance.

We interviewed program managers and transfer coordinators. Also, we reviewed competency files; credentialing and privileging folders; and the medical records of patients who were seen in the ED and subsequently transferred to other medical facilities, admitted to inpatient units within the medical center, or discharged home.

The ED is open 24 hours per day, 7 days per week, as required for ED designation. The ED environment and design are efficient, effective, and maintain patient privacy. Emergency services provided are within the facility's patient care capabilities. In addition, we found appropriate Memorandums of Understanding with local private facilities for managing patients whose care may exceed the medical center's capability.

Our review showed that clinical services; consultations; staffing; and medical record admission, discharge, and transfer documentation were appropriate. Electronic medical record documentation of patient care was easily identifiable, multidisciplinary, and complete.

We found that ED nursing staff annual competency assessments did not include high-risk, low-volume skills, including use of pediatric emergency equipment and medications. Because the ED is equipped with emergency pediatric equipment and medications, appropriate ED nursing staff must be evaluated annually to ensure that they maintain the necessary skills to use them safely and effectively. While we were onsite, the unit-specific annual competency skills evaluation list was modified to include these skills; therefore, we made no recommendations.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients. The purpose of this review was to assess the extent that the medical center used SHEP data to improve patient care, treatment, and services.

VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

The graphs on the next page show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure (PM) results for inpatients. Figure 2 shows the medical center's SHEP PM results for outpatients.

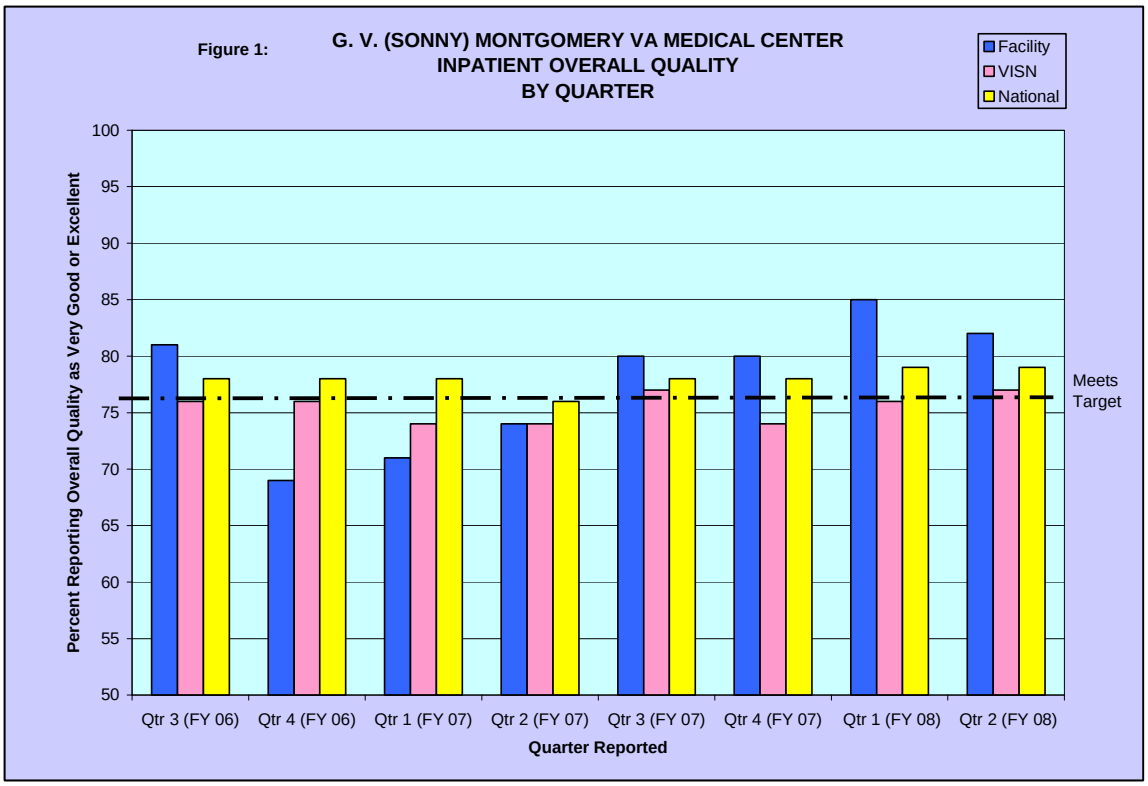
Figure 1:
G. V. (SONNY) MONTGOMERY VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
55
50
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

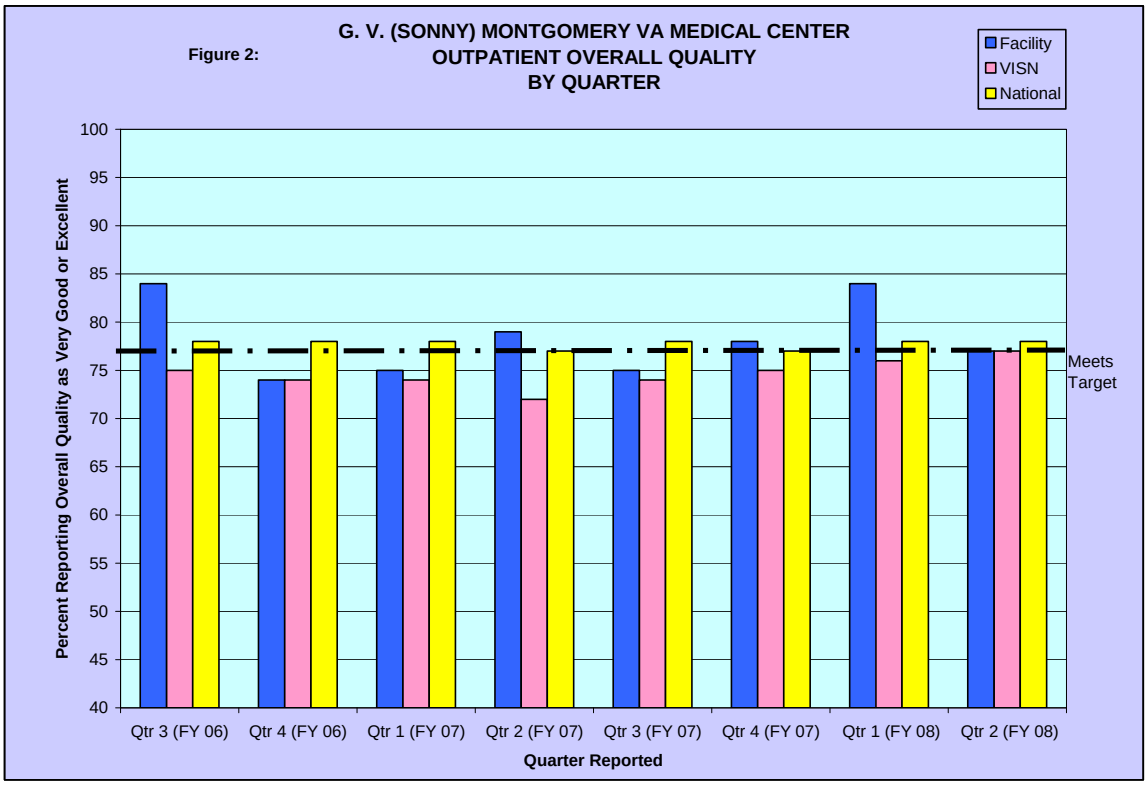
Figure 2:
G. V. (SONNY) MONTGOMERY VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
55
50
45
40
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

The medical center's inpatient overall SHEP scores from the 3rd quarter of FY 2006 through the 2nd quarter of FY 2008 met or exceeded the target in 5 of the 8 quarters. Outpatient scores also met or exceeded the target in 5 of the 8 quarters. The medical center had an active Customer Service Council (CSC), which included the Patient Advocate Program and the Patient Ombudsman Program. The CSC analyzed SHEP data, internal "quick card" survey comments, and data from an additional survey the medical center purchases that provides more immediate feedback to identify areas in need of improvement.

All survey results are communicated monthly to appropriate service managers. Two processes worthy of special note are (1) weekly peer reviews conducted by the patient advocate to ensure that patient complaint data are accurately entered into the Patient Advocate Tracking System and (2) a template note entered in the electronic medical record to document results of the follow-up call to discharged patients by the patient ombudsman. Because patient satisfaction was high and the actions of the CSC appeared to be effective, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 8, 2009

From: Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi**

To: Director, St. Petersburg Regional Office of Healthcare Inspections (54SP)

Director, Management Review Service (10B5)

I have reviewed the response to the subject CAP and concur.

(original signed by:)
George H. Gray, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 3, 2009

From: Director, G. V. (Sonny) Montgomery VA Medical Center (586/00)

Subject: **Combined Assessment Program Review of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi**

To: Director, South Central VA Health Care Network (10N16)

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 VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans for patients deemed at high risk for suicide.

Concur **Completion Date: 2/27/09**

Action Taken: A process has been implemented to ensure that all patents on the high risk list receive safety plans. Both the Suicide Prevention Coordinator and Suicide Case Manager conduct at a minimum, weekly chart audits to assess documentation compliance, including the completion of safety plans. This information is also reported to the Chief, Mental Health and the Chief of Staff (COS). Deficiencies noted are directly addressed with the appropriate provider for correction. Compliance is now at 100%.

A data dashboard that includes documentation of safety plans for all patients on the high risk list has also been developed for tracking by the Suicide Prevention Coordinator. This information is shared with facility Leadership during morning report.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the air ventilation outlets in the CLC and on acute inpatient unit 4CS are cleaned according to the standard operating procedure.

Concur: **Completion Date: 2/04/09**

Action Taken: The dirty air vents identified in the NHCU and 4CS were cleaned the same day of the finding. EMS has developed a schedule for cleaning air vents in all areas of the facility. This process will be verified and documented by visual supervisory oversight weekly and written supervisory oversight on a monthly basis.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the cleanliness of the dialysis unit is maintained.

Concur: **Completion Date: 1/28/09**

Action Taken: In addition to the end of day cleaning, EMS has scheduled Housekeeping to clean Hemodialysis (including the Prep Room) during the day shift at 1:30 p.m. Nursing staff in the Hemodialysis unit have been instructed to call EMS at any time during the workday when additional cleaning is needed.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of the medication room on the PACU is maintained.

Concur: **Completion Date: 1/28/09**

Action Taken: The door was closed and locked at the time of the finding. Nursing Service has counseled the responsible Nursing personnel on this issue. Security of the medication room in PACU has been added to the Nursing Supervisor daily rounds. Random audits have confirmed that the door is being kept closed and locked at all times.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews.

Concur: **Completion Date: 1/28/09**

Action Taken: Reviews continue to be tracked for compliance with the mandated timeframes by the Peer Review Coordinator. The majority of deficiencies were due to external reviews, especially specialty reviews.

The Peer Review Coordinator has broadened the list of reviewer facilities to request external review assignments. If no response is received from an outside facility within 2 days, VISN 16 Health System Specialist is contacted for assistance. VHA is currently in the process of securing contracts with outside facilities to conduct external peer reviews.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires full documentation of PRC discussions in committee minutes.

Concur **Completion Date: 2/06/09**

Action Taken: CAP Review recommendations have been incorporated into the PRC meeting minutes. More detail is now being included in the minutes to fully document the reasons when changes are made in the determination of levels.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.

Concur **Completion Date: 1/28/09**

Action Taken: Prior practice was based on guidance from Regional Counsel. Clarification has now also been obtained from VACO regarding disclosure of complications. Based on this clarification, disclosures are now being performed on all known complications.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that the effectiveness of PRN pain medication is documented in the electronic medical record within the medical center's required timeframe.

Concur **Target Completion Date: April 2009**

Action Taken: The PRN effectiveness data will be reported monthly in the Medical Records Committee meeting. Data will be reviewed by the Committee, and forwarded to Leadership through the Executive Committee of the Medical Staff (ECMS), Quality Executive Board (QEB), and Governance. The data will also be provided to the Head Nurses for action, if needed.

OIG Contact and Staff Acknowledgments

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Appendix D

Report Distribution

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