Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-01685-154

Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia

June 30, 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 April 20–24, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Louis A. Johnson VA Medical Center (the medical center), Clarksburg, WV. 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 26 employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

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

- Isolation Reference Cards.

We made recommendations in three of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP report. For these activities, the medical center needed to:

- Ensure that all inter-facility transfer documentation complies with Veterans Health Administration (VHA) policy.
- Ensure that patient privacy is protected in the emergency department (ED) triage area.
- Eliminate leaking water in the primary care waiting area.
- Ensure that environment of care (EOC) rounds are consistently attended by required team members and that all EOC rounds information is documented.
- Ensure that fire extinguisher signage complies with VA policy.
- Monitor the Canteen for cleanliness and ensure that scheduled cleanings are completed.
- Screen all community living center (CLC) patients for current tuberculosis (TB) testing.
- Ensure that clinicians discuss serious adverse events with patients and document the discussions.
- Ensure that medical record reviews are performed at the point of care by providers who document in the record.

- Monitor the copy and paste functions in the electronic medical record.
- Monitor and analyze the use of reversal agents in moderate sedation.
- Collect, analyze, review, and consider provider performance data as part of the reprivileging process.
- Ensure that designated staff maintain current cardiopulmonary resuscitation (CPR) certification.
- Require the local CPR policy to define actions to monitor compliance with CPR certification and actions to be taken when current certification is not maintained.

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

- Coordination of Care.
- Medication Management.
- Patient Satisfaction.
- Suicide Prevention Program.

This report was prepared under the direction of Nelson Miranda, Director, Washington, DC, 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 14–20, 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 located in Clarksburg, WV, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Parkersburg, Parsons, Sutton, and Westover, WV. The medical center is part of VISN 4 and serves a veteran population of about 70,000 throughout 26 counties in Maryland, Ohio, Pennsylvania, and West Virginia.

Programs. The medical center provides acute inpatient care for medicine, surgery, and psychiatry. It also provides residential rehabilitation and a variety of specialized outpatient services. The medical center has 100 hospital beds and 27 CLC[1] beds.

Affiliations and Research. The medical center is primarily affiliated with West Virginia University and provides training for approximately 100 residents, as well as other disciplines, including, pathology, radiology, ophthalmology, otolaryngology, and urology. In fiscal year (FY) 2008, the medical center research program had eight projects and a budget of approximately $375,000. Important areas of research included cardiology, bioterrorism, prostate cancer, and telehealth.

Resources. In FY 2008, medical care expenditures totaled approximately $120 million. The FY 2009 medical care budget is about $130 million. FY 2008 staffing was 692 full-time employee equivalents (FTE), including 55 physician and 230 nursing FTE.

Workload. In FY 2008, the medical center treated 19,676 unique patients and provided 19,471 inpatient days in the hospital and 8,419 inpatient days in the CLC. The inpatient care workload totaled 3,727 discharges, and the average daily census, including CLC patients, was 76.2. Outpatient workload totaled 211,833 visits.

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

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 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 seven activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through April 24, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia,* Report No. 06-01949-230, September 28, 2006). We had one repeat QM finding.

During this review, we also presented fraud and integrity awareness briefings for 26 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 reportable findings.

Organizational Strength

Isolation Reference Cards

Prevention of hospital-associated infectious disease transmission is a challenge to all medical facilities. The infection control team developed an innovative approach to educate and reinforce standard and transmission based isolation (STBI) requirements among employees, students, and volunteers. Small, laminated cards that fasten to medical center identification badges were created. On one side of the card is a descriptive reference outlining STBI signage; each type of isolation is color-coded. On the other side, requirements for personal protective equipment are listed. Isolation reference cards provide an accessible, visual clue and a quick resource prior to entering a patient's room. This tool helps to increase compliance with isolation precautions and decrease hospital-associated infections.

Results

Review Activities With Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in the ED, such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies.

We interviewed physicians, the ED program manager, and other staff. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. We reviewed the medical records of patients who received consults, were transferred to other medical facilities, or were admitted to inpatient units within the medical center.

Our review showed that clinical services and consults were appropriate. A staffing policy is in development that reflects the need for a full-time registered nurse for triage on all shifts. Emergency services provided are within the medical center's patient care capabilities. In addition, we found appropriate policies for managing patients whose care might exceed the medical center's capability.

We conducted an EOC tour and found that although space was limited, the ED was clean and safe. Plans for a new ED have been approved and are pending funding. The following areas needed improvement.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other medical facilities for care. Transfer documentation did not comply with VHA policy,[2] which requires the use of VA Form 10-2649A, "Inter-Facility Transfer Form," and/or the appropriate electronic medical record template note.

Patient Privacy. The ED triage area is located in the waiting room that serves the ED and two primary care clinics. The shared waiting room is crowded during business hours. The triage cubicle is not enclosed, and waiting room chairs are positioned in a way that compromises patient privacy.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that patient privacy is protected in the ED triage area.

The VISN and Medical Center Directors concurred with our findings and recommendations. The Chief of Staff will implement standardized use of the inter-facility transfer form. The ED triage station will be moved to ensure patient privacy. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA,

[2] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Occupational Safety and Health Administration, and external accreditation standards.

We conducted onsite inspections of ambulatory care areas, the medical-surgical unit, the intensive care unit, the CLC units, and the inpatient mental health unit. The medical center maintained a generally clean and safe environment. Although the inpatient mental health unit was not a locked unit, the medical center used VHA's Mental Health Environment of Care Checklist to identify environmental hazards that represented a potential threat to suicidal patients and took corrective actions to mitigate these hazards. We identified the following conditions that required attention.

Water Damage. The main entrance of the medical center is subject to water leaking through the glass façade and into the primary care patient waiting area during rainy/inclement weather. The problem is recurring and creates a patient safety issue. While we were onsite, medical center staff took action to temporarily mitigate damage and improve safety in this high traffic area.

EOC Rounds. The purpose of EOC rounds is to continuously assess the medical center's environment for functionality, safety, and cleanliness for patients, staff, and visitors. The EOC rounds team is led by the Associate Director, and membership includes the disciplines outlined in VA and local policy. However, we found that documentation of attendance on rounds did not begin until January 2009, after the EOC Committee identified problems with the process. Also, we were unable to track compliance with EOC rounds policies due to lack of documentation.

Fire Extinguishers. VA policy[3] requires that signage identifying the locations of fire extinguishers be clear and easily identifiable for patients, visitors, and staff. We found signage for fire extinguishers when there were none, and we found fire extinguishers without signage. Medical center staff took corrective action while we were onsite.

Infection Control. On a prior EOC inspection, the Canteen was cited for cleanliness issues in the food preparation and service areas. During our inspection, we found that the conditions remained unchanged and that scheduled

[3] Department of Veterans Affairs, *Fire Protection Design Manual*, 4th ed., November 2005.

cleanings were insufficient to maintain cleanliness. The medical center took corrective action while we were onsite.

TB Testing. We inspected the CLC for EOC issues, including TB prevention measures. Local policy requires documentation of a current, comprehensive medical assessment, including an initial medical history and physical examination, within 24 hours of admission. A vaccination history for tetanus, a pneumococcal vaccination, an influenza vaccination, and TB testing are required. We reviewed the medical records of 21 CLC patients and found that 7 (33 percent) of the records were not in compliance with local policy for TB testing.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that a permanent solution is implemented to eliminate water leaking into the primary care waiting area.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that EOC rounds are consistently attended by required team members and that all EOC rounds information is documented.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that fire extinguisher signage complies with VA policy.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director monitors the Canteen for cleanliness and ensures that scheduled cleanings are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that all CLC patients are screened for current TB testing.

The VISN and Medical Center Directors concurred with our findings and recommendations. Medical center staff took immediate action to mitigate water damage in the primary care patient waiting area and have undertaken administrative arrangements to procure funding to provide a permanent solution. Policy revisions are planned to ensure that EOC rounds include the required disciplines and are completed. Fire extinguisher signage has been corrected. The Canteen will be monitored for cleanliness, and the frequency of scheduled cleanings will be increased. Plans have been

developed to ensure that all CLC patients receive TB testing upon admission. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director and Chief of Staff, and we interviewed QM personnel. We evaluated plans, policies, performance improvement (PI) data, and other relevant documents.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Appropriate review structures were in place for 9 out of the 14 program activities reviewed. We identified the following five areas that needed improvement.

Adverse Event Disclosure. VHA regulations[4] require that clinicians disclose serious adverse events related to clinical care to patients or their personal representatives. We reviewed the medical records of six patients who experienced serious adverse outcomes during surgery and found that in four of the records, there was no documentation that clinicians discussed the events with the patients or their families.

Medical Records Review. VHA policy[5] and Joint Commission (JC) standards require that medical record documentation is reviewed at the point where care is delivered by the staff involved in delivering the care. This audit ensures that adequate, timely, complete, and properly authenticated documentation is being accomplished. We found that Health Information Management Service staff—not the staff delivering the care—performed the medical record reviews.

In addition, local policy states when it is appropriate to copy information from one part of the electronic medical record

[4] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[5] VHA Handbook 1907.1, *Health Information Management and Health Records*, August 25, 2006.

and paste it into a current progress note. However, the medical center did not monitor these functions to identify violations.

Operative and Other Procedures Reviews. VHA policy[6] requires that moderate sedation, including the use of reversal agents, be monitored and analyzed to improve patient safety. The medical center did not monitor or evaluate the use of reversal agents used in conjunction with moderate sedation.

Provider Performance Monitoring. VHA regulations[7] and JC standards require that clinical managers develop plans for continuous monitoring of the medical staff. According to the requirements, performance data monitoring should be ongoing, include indicators for continuing qualifications and competencies, be reviewed and considered during the reprivileging process, and be recorded in PSB minutes. At the time of our site visit, plans for ongoing competency monitoring were under development. We reviewed credentialing and privileging folders for 20 providers reprivileged in the past 12 months. We found that only one (5 percent) of the folders we reviewed had adequate data to support the privileges granted.

CPR Training. Local policy requires that the medical center have a system to routinely review compliance of designated staff with CPR certification requirements. We found that the medical center did not have such a system in place. Also we found that local policy did not define actions to track compliance and actions that would be taken if a designated individual failed to maintain current certification. During our site visit, additional CPR classes were held, but there were still designated individuals who were not certified.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians discuss serious adverse events with patients and document these discussions in the patients' medical records.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews

[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2006.
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

are performed at the point of care by providers who document in the record.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires monitoring of the copy and paste functions in the electronic medical record to identify violations.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that the use of reversal agents in moderate sedation is monitored and analyzed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that provider performance data are collected, analyzed, reviewed, and considered during the reprivileging process, in accordance with VHA policy.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR certification.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that local CPR policy defines actions to monitor compliance with CPR certification and actions to be taken when current certification is not maintained.

The VISN and Medical Center Directors concurred with our findings and recommendations. Monitoring of the disclosure of serious adverse events will be increased by submitting quarterly reports to the Medical Executive Committee. Systems for point of care medical record reviews and for monitoring the copy and paste functions will be implemented. The use of reversal agents in moderate sedation will be routinely reviewed. The systems for collection and review of provider performance data will be enhanced. The system to track CPR certification will be enhanced, and compliance will be tracked. Also, the local CPR policy will be revised. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 15 inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes. We determined that clinicians appropriately managed all 12 intra-facility transfers and that there was documented nurse-to-nurse and physician-to-physician hand-off communication. Also, we reviewed the medical records of 13 discharged patients and found that all patients received appropriate written discharge instructions. We also found that discharge instructions and discharge orders were generally consistent with provider discharge summaries and that there was evidence that patients or their family members understood and received copies of discharge instructions. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

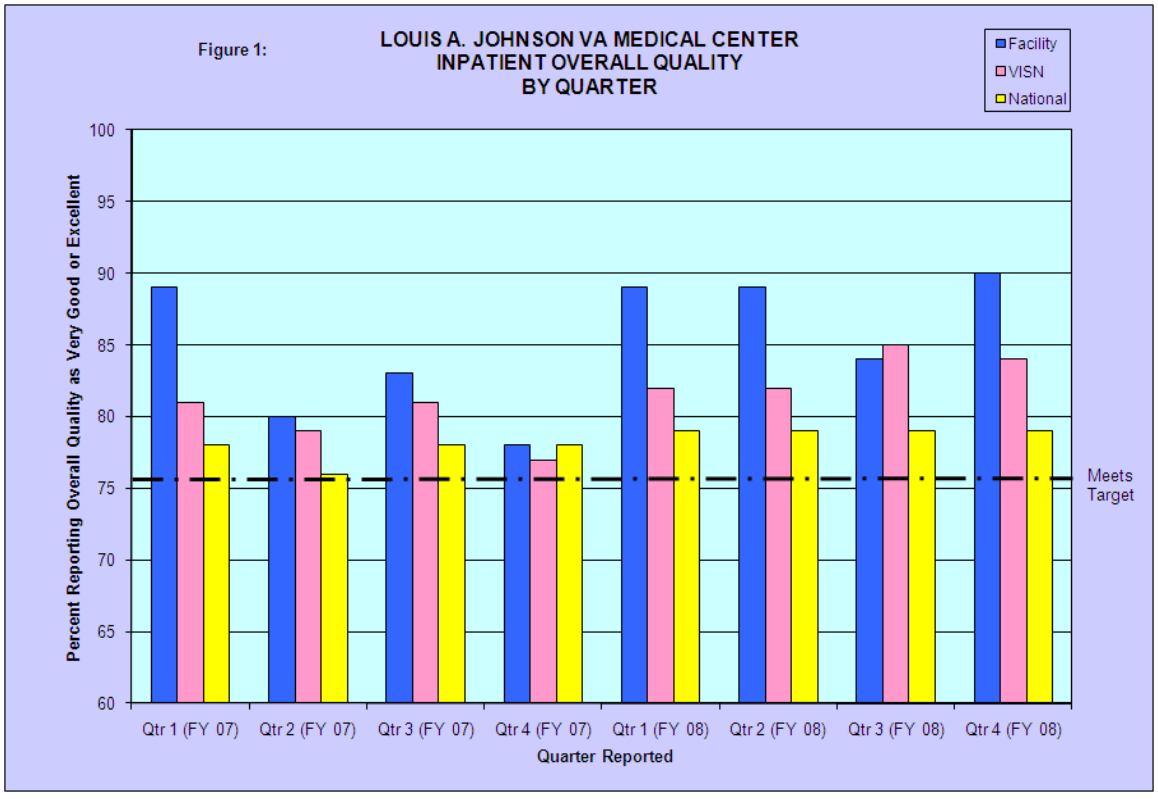
We reviewed selected medication management processes in the inpatient medical-surgical units and in the intensive care unit. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers prior to medication administration.

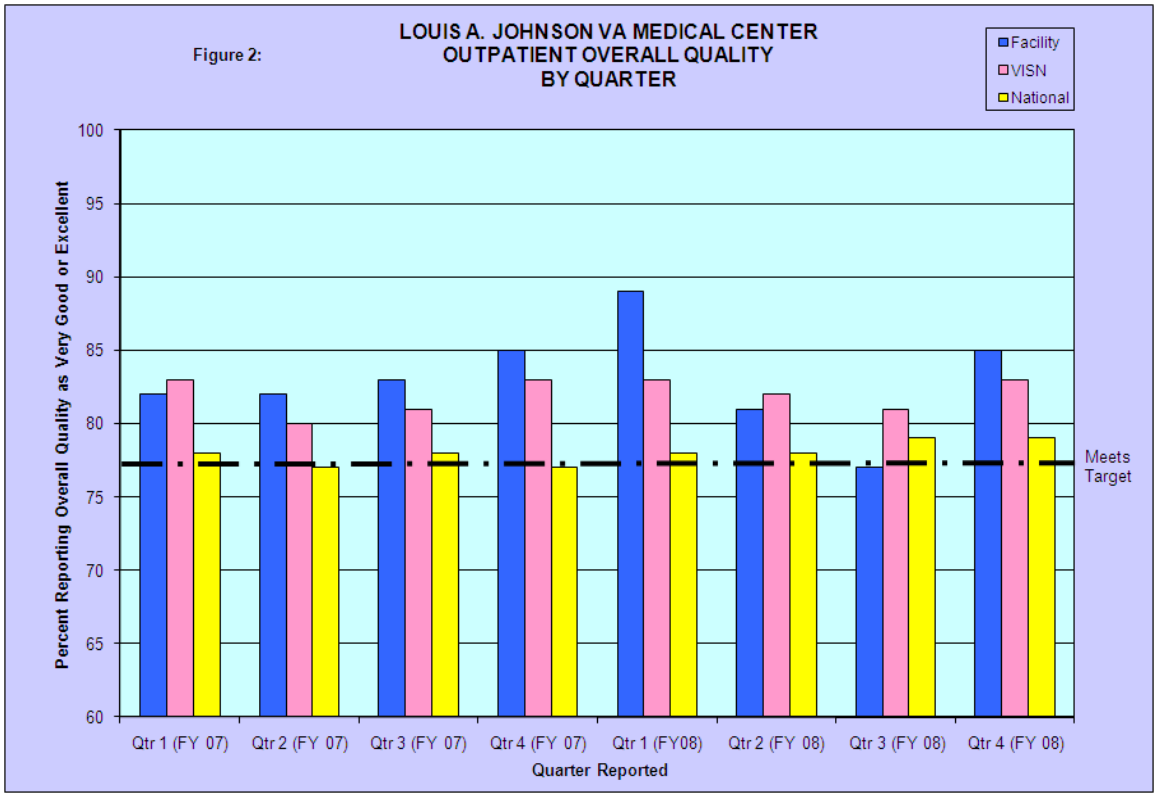
We reviewed the Bar Code Medication Administration records of 48 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. We found that nurses documented pain medication effectiveness within the local policy's required timeframe of 4 hours 81 percent of the time. We made no recommendations.

Patient Satisfaction

The purpose of this review was to assess the extent that VHA medical centers used quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for the Survey of Healthcare Experiences of Patients (SHEP). VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 1st quarter of FY 2007 and ending with the 4th quarter of FY 2008. Figures 1 and 2 (below and on the next page) show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center's inpatient and outpatient scores met or exceeded the target in all 8 quarters. The medical center's Director shared SHEP data with staff, service chiefs, and patients. All data were analyzed, and actions were taken when appropriate. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs.[8] In addition, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[9] documented safety plans that addressed suicidality, and documented collaboration between mental health providers and SPCs.

We interviewed the medical center's SPC and the mental health providers on the Suicide Risk Group Committee, and we reviewed pertinent policies and the medical records of 17 patients determined to be at risk for suicide. We found

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

that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required functions. We also found that all the medical records contained PRFs, acceptable safety plans, and evidence of collaboration between the SPC and mental health providers. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 28 May 2009

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

Subject: **Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia**

To: Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

I have reviewed the response to the draft OIG CAP report provided by Louis A. Johnson Healthcare System and concur with the response. I am submitting it to your office as requested. If you have nay questions or require additional information, please contact Barbara Forsha, VISN QMO, at 412 882-3290.

(original signed by:)

Michael E. Moreland, FACHE

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 28 May 2009

From: Medical Center Director

Subject: **Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia**

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

We concur with the OIG recommendations.

(original signed by:)

William E. Cox

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 VISN Director ensure that the Medical Center Director requires that all inter-facility transfer documentation complies with VHA policy.

Concur

1.1 Implement the use of VA Form 10-2649A, "Interfacility Transfer Form," alternatively, an electronic template transfer note during non-administrative hours.

Responsibility: Chief of Staff

Target Date: Implementation of 24/7 standardized documentation by July 30, 2009.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that patient privacy is protected in the ED triage area.

Concur

2.1 Re-locate ED triage station to allow for enhanced patient privacy.

2.2 Construction project to renovate ED.

Responsibility: Chief, Facilities Management

Target Date: Construction project to begin August 2009

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that a permanent solution is implemented to eliminate water leaking into the primary care waiting area.

Concur

3.1 Glazing project will be completed as permanent solution to rain water leaking into patient care area.

Responsibility: Chief, Facility Management

Target Date: October 1, 2009

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that EOC rounds are consistently attended by required team members and that all EOC rounds information is documented.

Concur

4.1 Revise EOC rounding routine to include a designated fill-in member for any discipline not able to attend a scheduled round. Quarterly Environment of Care rounds attendance reports at Environment of Care Committee.

4.2 Revise EOC round aggregate report format and present quarterly at EOC Committee meeting.

Responsibility: Associate Director

Target Date: October 1, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that fire extinguisher signage complies with VA policy.

Concur

5.1 All Fire Extinguisher signage will comply with VA policy. Of note, the single finding which prompted this recommendation was corrected while the reviewers were on station. Signage corrected during site visit. Appropriate signage will be a line item on Environment of Care rounds and report rolled up to Environment of Care Committee.

Responsibility: Chief, Facilities Management

Target Date: Complete

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director monitors the Canteen for cleanliness and ensures that scheduled cleanings are completed.

Concur

6.1 Enforce compliance with CLC patients tuberculosis testing. Medical Director/Nurse Manager of CLC to provide check and balance for testing for all new admissions. CLC quarterly monitor report to Medical Executive Committee.

Responsibility: Infection Control Practitioner

Target Date: July 30, 2009

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that all CLC patients are screened for current TB testing.

Concur

7.1 Enhance monitoring of cleanliness and scheduled cleanings for the Canteen Food Service area. Increase daily rounds of housekeeping staff. Environment of Care rounds reported quarterly to Environment of Care Committee.

Responsibility: Associate Director with Chief, VCS

Target Date: July 30, 2009

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians discuss serious adverse events with patients and document these discussions in the patients' medical records.

Concur

8.1 Increase compliance with discussion and documentation of clinical disclosures. Education to clinical staff. Ongoing review of surgical progress notes. Quarterly disclosure report to Medical Executive Committee.

Responsibility: Chief of Staff with Chief, Quality

Target Date: July 30, 2009

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews are performed at the point of care by providers who document in the record.

Concur

9.1 Implement system for point of care medical record reviews and forward these reviews to Medical Record Review Committee.

Responsibility: Chief of Staff with Chair, Medical Record Review Committee.

Target Date: July 30, 2009.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires monitoring of the copy and paste functions in the electronic medical record to identify violations.

Concur

10.1 Implement system for the monitoring of copy and paste function and report this review to Medical Record Review Committee.

Responsibility: Chief of Staff with Chair, Medical Record Review Committee

Target Date: July 30, 2009

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that the use of reversal agents in moderate sedation is monitored and analyzed.

Concur

11.1 Implement a routine review of the use of reversal agents in moderate sedation episodes of care and report this review through Operative & Invasive Procedure Review Committee to the Medical Executive Council.

Responsibility: Chief, Surgery with NSQIP Nurse Reviewer

Target Date: July 30, 2009

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that provider performance data are collected, analyzed, reviewed, and considered during the reprivileging process, in accordance with VHA policy.

Concur

12.1 Enhance the system for collection, analysis, and review of provider performance data.

12.2 Enhance the system for consideration, discussion, and documentation of this activity in the PSB minutes.

Responsibility: Chief of Staff with Risk Manager

Target Date: July 30, 2009

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR certification.

13.1 Enhance the system utilized to track and maintain current CPR certification in accordance with local policy.

13.2 Implement routine reports of compliance to Medical Executive Council.

Concur

Responsibility: Associate Director, Patient Care Services with Chief of Staff

Target Date: July 30, 2009

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that local CPR policy defines actions to monitor compliance with CPR certification and actions to be taken when current certification is not maintained.

Concur

14.1 Revise the local CPR policy to describe a process for monitoring staff compliance and define actions that will be taken if staff fails to comply.

Responsibility: Associate Director, Patient Care Services with Chief of Staff.

Target Date: July 30, 2009

OIG Contact and Staff Acknowledgments

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