Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03272-70

Combined Assessment Program Review of the James J. Peters VA Medical Center Bronx, New York

January 25, 2010

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 November 2–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the James J. Peters VA Medical Center (the medical center), Bronx, NY. 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 302 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 3.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Re-admission rates of patients with congestive heart failure (CHF).
- Medication wall carts.

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

- Monitor and evaluate the use of reversal agents in conjunction with moderate sedation.
- Develop an action plan to ensure timely renewal of Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) certifications.
- Develop processes to monitor the use of the copy and paste functions and report trends to the appropriate committee.
- Fully implement professional practice evaluations and include supporting provider-specific profiles and ensure that Professional Standards Board (PSB) meeting minutes reflect discussions regarding performance data.
- Correct the safety risk posed by wall-mounted light fixtures on the acute mental health (MH) unit.
- Ensure that acute MH unit staff receive the mandatory environmental hazard training.
- Comply with local policy governing nursing transfer documentation.

- Ensure that Veterans Health Administration (VHA) required elements are included in discharge summaries and instructions and that the information is consistent.
- Ensure that magnetic resonance imaging (MRI) technologists screen all patients prior to MRI procedures and document the screening in the medical record.

The medical center complied with selected standards in the following activity:

- Medication Management.

This report was prepared under the direction of Jeanne Martin, PharmD, Associate Director, Boston 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 13–17, for 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 provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics in Bronx, Yonkers, Sunnyside, and White Plains, NY. The medical center is part of VISN 3 and serves a veteran population of more than 323,700 in the New York counties of Queens, Bronx, and Westchester.

Programs. The medical center provides primary care, tertiary care, and long-term care services in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, radiation oncology, spinal cord injury, and polytrauma. It has 212 operating hospital beds and 84 operating community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with Mount Sinai School of Medicine, the Hospital for Special Surgery, and Columbia University's College of Physicians and Surgeons and provides training for approximately 700 residents. It also provides training for other disciplines, including dietetics, pharmacy, and health care administration. In fiscal year (FY) 2009, the medical center research program had 31 projects and a budget of $6.6 million. Important areas of research included psychiatry, spinal cord injury, and health services.

Resources. In FY 2009, medical care expenditures totaled over $188 million. The FY 2010 medical care budget is estimated to be more than $189 million. FY 2010 staffing is 1,677 full-time employee equivalents (FTE), including 139 physician and 494 nursing FTE.

Workload. In FY 2008, the medical center treated almost 25,000 unique patients and provided approximately 55,300 inpatient days in the hospital and 25,900 inpatient days in the CLC units. The inpatient care workload totaled 4,854 discharges, and the average daily census, including CLC patients, was 223. Outpatient workload totaled 323,188 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.
- 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 six activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Credentialing & Privileging (C&P).
- QM.

The review covered medical center operations for FY 2008 and FY 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York*, Report No. 06-01134-20, November 6, 2006).

In that report, we recommended that: (a) the medical center develop and implement strategies to improve compliance with medical center and Joint Commission (JC) standards governing restraint use, (b) the medical center correct

identified deficiencies in the community nursing home program, and (c) the medical center take action to track and trend provider-specific compliance with diabetes performance measures. We found sufficient evidence that managers had implemented appropriate actions to address the recommendations, and we consider the issues closed.

During this review, we also presented fraud and integrity awareness briefings for 302 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 Strengths

Re-Admission Rates of Patients with Congestive Heart Failure

Heart damage caused by a heart attack or some other heart condition may result in CHF, the inability of the heart to function effectively. The severity of CHF symptoms depends on the extent of the initial damage and proper management of impaired heart function thereafter. Heart patients with CHF may require close monitoring of subtle changes in their condition to prevent an acute exacerbation of CHF symptoms.

During the 1st quarter of FY 2009, 17 CHF patients were re-admitted to the medical center within 14–30 days of discharge. Medical center managers appointed a task force to identify factors that were contributing to the high re-admission rate and set a goal to reduce the rate by 10 percent. The task force determined that at the time of discharge, patients were not consistently provided with follow-up appointments and that not all qualified patients were enrolled in Telehealth (use of telecommunications for preventive health services). Additionally, the task force found that patient support systems after discharge were limited.

In April 2009, the medical center instituted measures to ensure timely follow-up appointments and enrollment in Telehealth prior to discharge. Post-discharge support was improved with the use of community resources, such as

visiting nursing services. During the 4th quarter of FY 2009, the rate of re-admitted CHF patients decreased by 41 percent to 10 re-admissions within the 14–30 day timeframe.

Medication Wall Carts

The medical center identified problem areas in medication administration practices related to equipment. Medication carts with individual patient medication drawers were difficult to maneuver and frequently had faulty locking mechanisms. Computers attached to the carts, necessary for bar code medication administration (BCMA), often had insufficient battery memory to complete a medication pass. Because of these equipment problems, nursing staff frequently removed individual medication drawers from the carts to bring to patient rooms rather than relocate the carts. In addition to the equipment problems, pharmacy technicians often replaced medication drawers before the entire day's medications were administered, causing missing doses for oncoming shifts. Pharmacy received 337 missing dose reports in 1 month from one unit.

The medical center researched medication storage systems and elected to install computerized wall carts in each patient room on a test unit. Individual access codes are required to enter the wall cart and open the medication drawers. Nursing staff administer medications from the wall cart in the patient's room in conjunction with a small mobile computer. After the use of wall carts was instituted, medication administration practices improved, and missing dose reports decreased by 34 percent. The medical center has plans to install wall carts in all inpatient rooms.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents. We interviewed appropriate senior managers, patient safety employees, and the QM coordinator.

The medical center's 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. However, we identified three areas that needed improvement.

Moderate Sedation. VHA regulations[1] and local policy require the monitoring of compliance with defined protocols, including trending the use of reversal agents and reporting the results to the appropriate committee. We found no evidence that the medical center monitored or evaluated the use of reversal agents in conjunction with moderate sedation.

Life Support Training. VHA regulations[2] require that the medical center monitors BLS and ACLS training and ensures timely renewal of all certifications. We found that the medical center was appropriately monitoring training but not ensuring timely renewal. Managers identified 360 employees requiring BLS certification; however, 51 (14 percent) did not have current certificates. Three of the BLS certifications had expired on or before January 1, 2009. In addition, of the 197 employees identified as requiring ACLS certification, 39 (20 percent) did not have current certificates.

Medical Record Documentation. VHA regulations[3] and VISN policy require that managers monitor the copy and paste functions in the Computerized Patient Record System for inappropriate use and report violations to the Medical Staff Committee for corrective actions. While VHA requirements for monitoring have been in place since 2006, medical center managers did not begin monitoring the use of these functions until October 2009. Consequently, insufficient data have been collected to allow for identification of system issues or trending.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers monitor and evaluate the use of reversal agents in conjunction with moderate sedation, as required by VHA and local policy.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

managers develop an action plan to ensure timely renewal of all BLS and ACLS certifications.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers monitor the use of the copy and paste functions and report trends to the appropriate committee.

The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center managers will collect data on conscious sedation, including the use of reversal agents, and the data will be reported to the appropriate committees. In order to ensure timeliness with BLS and ACLS re-certification, the medical center will use the VA Learning Management System. The designated learning officer will monitor compliance and submit quarterly reports to the appropriate committee. A quarterly audit will be conducted to monitor the copy and paste functions, and results will be reported to the Board of Directors Council. Data will be aggregated and analyzed quarterly, and findings will be reported to the PI Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P physicians. For a sample of physicians, we reviewed selected elements required by VHA regulations[4] in C&P files. We also reviewed PSB meeting minutes during which discussions about the physicians took place.

We reviewed 16 physicians' C&P files. The physicians were either appointed to the medical staff or reprivileged in the past 12 months. We found that licenses were current and that primary source verification[5] was obtained. However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA regulations require specific competency criteria for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. Although clinical managers had developed service-specific criteria for practice evaluations in June 2009, the plan was

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[5] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

not fully implemented at the time of our CAP review. As a result, we did not find supporting provider-specific profiles for any of the 16 physicians' files. Also, we did not find evidence of FPPE data for three newly appointed physicians or OPPE data for the remaining 13 reprivileged physicians. In addition, PSB meeting minutes did not reflect detailed discussions of physicians' performance data prior to reprivileging.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that professional practice evaluations be fully implemented and include supporting provider-specific profiles and that PSB meeting minutes reflect discussions regarding performance data.

The VISN and Medical Center Directors agreed with the findings and recommendation. A process to create individual provider performance profiles for FPPE and OPPE has been initiated, and PSB minutes will include discussions of supporting provider-specific performance profiles. The implementation 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. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and accreditation requirements.

We inspected the following areas: (a) two medical/surgical units, (b) the intensive care unit (ICU), (c) the acute MH unit, (d) two CLC units, (e) the spinal cord injury unit, and (f) the dialysis unit. The inspected areas were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their areas.

We reviewed fire drill reports for quarters 1–4 of FY 2009 and found that managers conducted fire drills as required and assessed personnel and equipment performance. Also, the medical center provided documentation of risk assessment and abatement tracking of safety issues previously identified on the acute MH unit. However, we identified the following area that needed improvement.

Safety. Wall-mounted light fixtures in bathrooms located within some patient rooms on the acute MH unit posed a potential hanging risk. In addition, employees assigned to locked inpatient MH units are required to undergo annual training on the identification of environmental hazards that pose a risk to suicidal patients.[6] Of the 31 employees assigned to the unit, 12 (39 percent) did not have documentation of the required annual environmental hazard training.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that managers correct the safety risk posed by wall-mounted light fixtures on the acute MH unit.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that staff assigned to the acute MH unit receive the mandatory annual environmental hazard training.

The VISN and Medical Center Directors agreed with the findings and recommendations. The three wall-mounted light fixtures cited on the acute MH unit have been replaced. In addition, as of December 1, 2009, all required staff have completed MH environmental hazard training. The corrective actions are acceptable, and we consider these two recommendations closed.

Coordination of Care

The purpose of this review was to evaluate whether intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and accreditation standards. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We found that MH discharge documentation included follow-up MH appointments and emergency MH services information. However, we identified two areas that needed improvement.

Intra-Facility Transfers. Local policy governing nursing transfer documentation requires that specific elements be included in the nursing transfer note. We reviewed

[6] Deputy Undersecretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

17 transfer notes and found that two elements required by local policy (patient orientation and physician notification of the patient's arrival) were not consistently documented.

Discharges. VHA regulations[7] require that specific elements be included in discharge documentation. We reviewed 18 discharges and found that in 14 (78 percent) of the 18 medical records, various elements required by VHA were missing in either the discharge summary or instructions. Additionally, when the elements were included in both documents, they were not always consistent. For example, we found six records where diet or follow-up instructions differed between the summaries and instructions.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing transfer documentation comply with local policy.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries and instructions include all VHA required elements and that the information in the discharge documentation is consistent.

The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center managers convened a PI team. Team members are developing an improved process to ensure consistency in transfer and discharge documentation. This will ensure compliance with local policy. Also, the discharge summary and discharge instructions template was modified to facilitate compliance with VHA regulations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the medical center had adequate safety policies and had conducted a risk assessment of the environment, as required by the JC.

[7] VHA Handbook 1907.01.

The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a call system while in the scanner.

We reviewed the training records of four MRI personnel and found that all four had completed appropriate safety training specific to their MRI zone level access. Additionally, we reviewed the training records of five support (non-MRI) personnel who had access to the MRI area and found that all five had completed MRI safety training. However, we identified one area that needed improvement.

Screening. All patients should undergo safety screening prior to MRI procedures.[8] We reviewed the medical records of 10 patients who underwent an MRI procedure during the month of September 2009 to determine if MRI technologists conducted required screening. Although MRI technologists reported screening all patients as required, and we witnessed technologists screening patients during our visit, technologists reported that they do not document screening in the patient's medical record.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that MRI technologists screen all patients prior to MRI procedures and that the screening be documented in the patient's medical record.

The VISN and Medical Center Directors agreed with the finding and recommendation. The Diagnostics Patient Care Center Director has implemented an electronic documentation process for MRI technologists. This process was implemented the week after the OIG's visit. Compliance will be monitored, and results will be reported to the PI Committee quarterly. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication

[8] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Sec. 4.3.

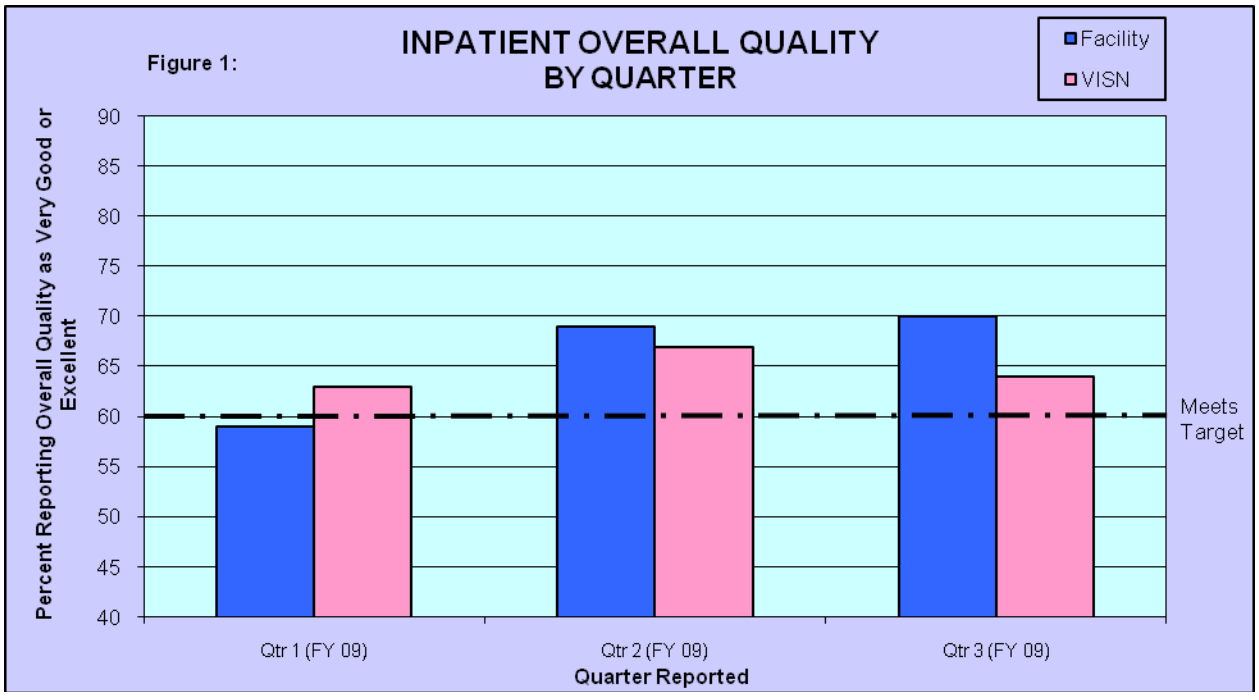
management processes in three inpatient units—the ICU and the acute MH and CLC units.

We found that the medical center had a designated BCMA program coordinator and that pharmacy staff completed monthly medication reviews for CLC patients. Additionally, we found that reassessments for 79 (82 percent) out of 96 administered doses of PRN[9] pain medications reviewed for the period of August 23–25, 2009, were documented within the timeframe required by local policy. We made no recommendations.

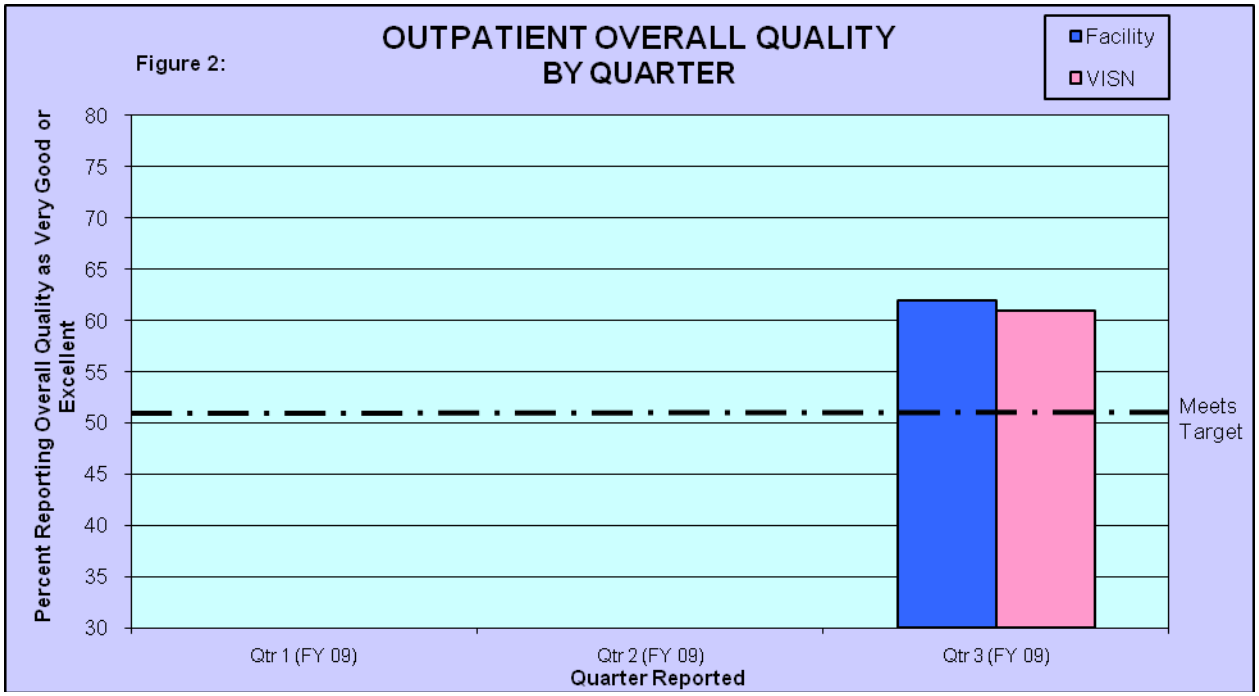
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[10] The target scores are noted on the graphs.

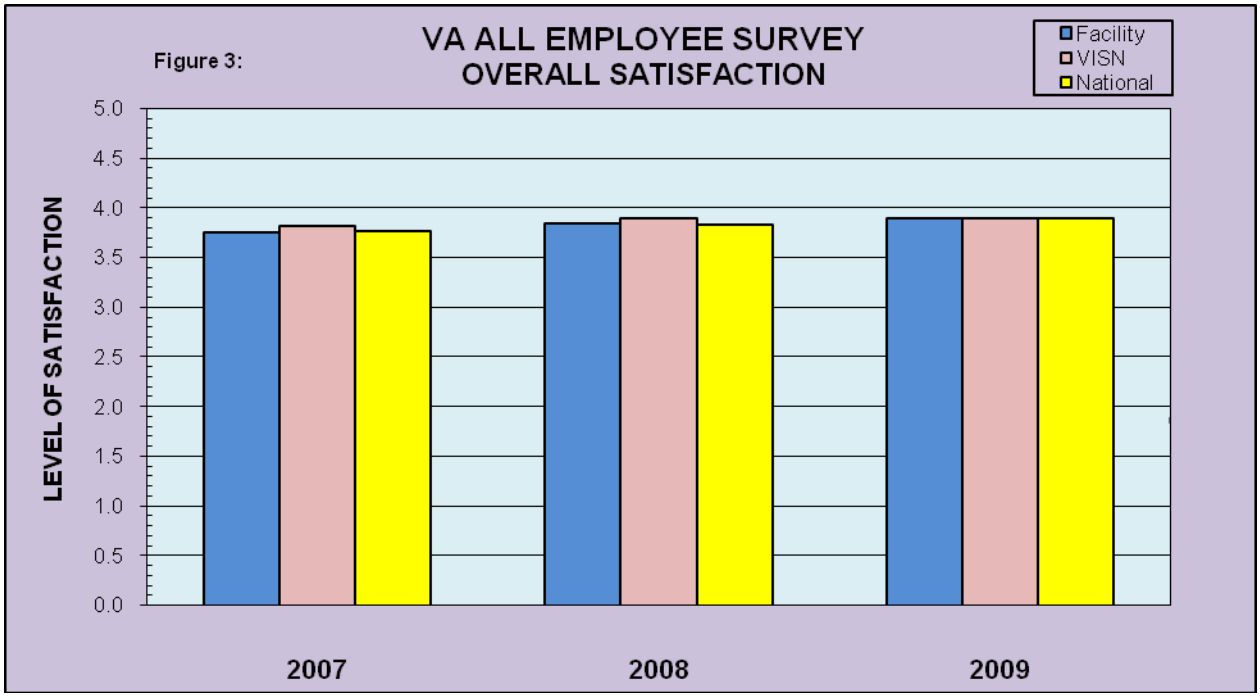
Figure 1:



[9] PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as the circumstances require.
[10] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 21, 2009

From: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subject: **Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York**

To: Associate Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Service (10B5)

Attached please find the Combined Assessment Program (CAP) draft response from the James J. Peters VA Medical Center.

I have reviewed the draft report for the James J. Peters VA Medical Center and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at the James J. Peters VA Medical Center.

Michael A. Sabo, Director,
VA New York/New Jersey Veterans Healthcare Network

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 21, 2009

From: Director, James J. Peters VA Medical Center (526/00)

Subject: **Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York**

To: Associate Director, Boston Healthcare Inspections Division (54BN)

Director, Management Review Service (10B5)

The recommendations of the Combined Assessment Program Draft Report of the James J Peters VA Medical Center conducted by the OIG team during the week of November 2–6, 2009, have been reviewed.

Recommendations number 5 and 6 were completed during the actual survey dates. Recommendation 9 was completed during the week immediately after the CAP survey visit. The attached response with action plans are being submitted for your consideration.

Thank you,

(original signed by:)
MARY ANN MUSUMECI
Director, James J Peters Bronx VAMC

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 medical center managers monitor and evaluate the use of reversal agents in conjunction with moderate sedation, as required by VHA and local policy.

Concur Implementation Date: Completed

On December 16, 2009, the Patient Care Center Director for Perioperative Care forwarded the first set of data collected on conscious sedation, including the use of reversal agents, to the Operating Room Committee as stated in the hospital policy. This information will also be reported to the Performance Improvement Committee (PIC) on a monthly basis.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers develop an action plan to ensure timely renewal of all BLS and ACLS certifications.

Concur Implementation Date: February 16, 2010

Ninety-two percent of staff requiring ACLS and BCLS certification have completed training. All staff will have completed training by February 16, 2010.

In order to ensure timeliness with ACLS and BCLS re-certification, data will be entered into the VA Learning Management System (LMS). VA LMS will send an email 90 days prior to expiration to remind staff that re-certification needs to be completed. The designated learning officer will monitor compliance and will submit a report to the Cardiopulmonary Resuscitation committee on a quarterly basis.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers monitor the use of the copy and paste functions and report trends to the appropriate committee.

Concur Implementation Date: Completed

The compliance program team conducted a preliminary report on the cutting and pasting functions in the medical record. A quarterly audit of thirty medical records will be conducted as a monitoring process for further validation and reported to the Board of Directors Council.

The monitoring of cutting and pasting has also been added to the clinical pertinent reviews. The Medical Record Committee will do data aggregation and analysis on a quarterly basis and forward the findings to the PIC.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that professional practice evaluations be fully implemented and include supporting provider-specific profiles and that PSB meeting minutes reflect discussions regarding performance data.

Concur Implementation Date: December 30, 2009

A process to create individual provider performance profiles for FPPE and OPPE has been initiated. The profiles will include specific competency criteria, targets, and data sources. They will be stored securely with access for practice/service chiefs. The first report to the PSB will be completed 12/30/09.

A practice that PSB minutes include supporting provider specific performance profiles has been implemented as of November 30, 2009. The minutes will reflect discussion of performance led by service chief/designee given at the PSB for re-appointed or newly hired providers.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that managers correct the safety risk posed by wall-mounted light fixtures on the acute MH unit.

Concur Implementation Date: Completed

The three wall-mounted light fixtures sited on the acute mental health unit have been replaced.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff assigned to the acute inpatient MH unit receive the mandatory environmental hazard training.

Concur Implementation Date: Completed

At the time of the survey, 67 percent of staff assigned to the inpatient MH unit had completed mandatory environmental hazard training. As of December 1, all required staff had completed the mandatory training.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing transfer documentation comply with local policy.

Concur Implementation Date: January 29, 2010

A performance improvement team was convened to address recommendations 7 and 8. The team members have started to develop an improved process to ensure consistency in the transfer and discharge documentation. This will ensure compliance with the existing policy.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries and instructions include all VHA required elements and that the information in the discharge documentation is consistent.

Concur Implementation Date: December 8, 2009

As above, the discharge summary and discharge instructions template was modified on December 8 to facilitate compliance with VHA Handbook 1907.01.

Compliance with documentation of the required elements will be monitored and tracked by the performance improvement department.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that MRI technologists screen all patients prior to MRI procedures and that the screening be documented in the patient's medical record.

Concur Implementation Date: Completed

The MRI technologists have always reviewed the MRI questionnaire with patients before the procedure. It was found during the survey that the review was not documented in the medical record. The Diagnostics Patient Care Center Director has implemented a documentation process for MRI technologists to screen patients prior to entering the MRI suite in VISTA. This process was immediately implemented the week after the IG visit.

The Diagnostics Patient Care Center Director will do a review in December to assure compliance with the process and quarterly thereafter. This will be reported to the PIC on a quarterly basis.

OIG Contact and Staff Acknowledgments

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