Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.11-00031-197

Combined Assessment Program Review of the Oklahoma City VA Medical Center Oklahoma City, Oklahoma

June 10, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

ACLS	Advanced Cardiac Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CRC	Cardiopulmonary Resuscitation Committee
CWAD	Crisis, Warning, Allergies and/or Adverse Reactions, and Directives
EOC	environment of care
facility	Oklahoma City VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IC	infection control
JC	Joint Commission
MDRO	multidrug-resistant organisms
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
QM	quality management
SOPs	standard operating procedures
SPICE	Safety/Performance Improvement/Clinical Executive Committee
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Oklahoma City VA Medical Center, Oklahoma City, OK

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 7, 2011.

Review Results: The review covered seven activities and one follow-up review area.

Recommendations: We made recommendations in the following seven activities and follow-up review area:

Physician Credentialing and Privileging: Initiate Focused Professional Practice Evaluations for all applicable physicians, and report results. Maintain adequate competency data in all physicians' profiles.

Coordination of Care: Provide and document advance directive notification and screening. Scan all advance directives into the electronic medical record, and link advance care planning notes to the clinical alert posting. Provide copies of completed advance directives to patients.

Management of Test Results: Document the time critical results were communicated to ordering providers. Document notification and treatment actions for critical results. Communicate normal results to patients within the specified timeframe.

Medication Management: Dispose of protective gowns worn during the hazardous drug compounding process immediately upon removal. Separate clean and dirty supplies during chemotherapy administration.

Management of Multidrug-Resistant Organisms: Provide infection prevention strategies education to affected patients and their families, and document it. Educate employees annually, and document it.

Environment of Care: Complete required training for designated employees, and document it. Develop a system to verify annual inspection of radiation shields and aprons. Secure patient information in the medical intensive care unit.

Quality Management: Provide the required service-level medical record reviews, and include all required components.

Follow-Up on Cardiopulmonary Resuscitation and Advanced Cardiac Life Support Training and Certification: Ensure required staff maintain current certification.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area:

- COC
- EOC
- Follow-Up on CPR and ACLS Training and Certification
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through March 7, 2011, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on the recommendation from our prior CAP review of the facility (*Combined Assessment Program*

Review of the Oklahoma City VA Medical Center, Oklahoma City, Oklahoma, Report No. 08-01266-176, August 1, 2008). (See Appendix B for further details.) The facility had a repeat finding in CPR and ACLS training and certification.

During this review, we also presented crime awareness briefings for 385 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.

Results

Review Activities With Recommendations

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that an FPPE be initiated for all physicians who have been newly hired or have added new privileges and that the Clinical Executive Committee review recommendations.[1] Only three of the five applicable physicians whose profiles we reviewed had an FPPE implemented. Only two of the three completed FPPEs were reported to SPICE.

OPPE. VHA also requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing periodic basis. Only four of the eight applicable physician profiles reviewed had evidence of data for the previous 4 quarterly OPPE periods.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Recommendations

1. We recommended that FPPEs be initiated for all applicable physicians and that results be reported to SPICE.

2. We recommended that processes be strengthened to ensure that adequate competency data is maintained in all physicians' profiles.

COC

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

We reviewed 14 patients' medical records for evidence of advance care planning, advance directives, and discharge instructions. We identified the following areas that needed improvement.

Advance Directive Notification and Screening. VHA requires that patients be given written notification at each admission stating their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[2] We found evidence of written notification in only 2 of the 14 medical records.

VHA also requires that facility staff ask patients whether they have an advance directive and whether they want more information and/or assistance in completing the advance directive forms. We found evidence of screening in only 11 of the 14 medical records.

Management of Advance Directive Documents. VHA requires that advance directives be filed in patient medical records and that the patient receive a copy of the completed advance directive. Six of the 14 medical records indicated the presence of advance directives. Electronic copies of advance directives were present in four of the six records. Only one of the six records contained documentation that the patient received a copy of the completed advance directive.

VHA also requires that staff use specific progress note titles when documenting advance care planning discussions with patients and link these notes to the CWAD postings in the electronic medical record. Advance directive notes were linked to CWAD postings in only 2 of the 14 medical records.

[2] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009. All references to VHA requirements in this section refer to this directive.

Recommendations

3. We recommended that processes be strengthened to ensure that staff provide and document advance directive notification and screening at each inpatient admission.

4. We recommended that processes be strengthened to ensure that all advance directives are scanned into the electronic medical record and that patient advance care planning progress notes are linked to the CWAD posting.

5. We recommended that a copy of the completed advance directive document be provided to the patient.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[3]

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

Documentation of Ordering Provider Notification. VHA requires that diagnostic laboratory, radiology, and pathology clinicians document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[4] We reviewed the medical records of 30 patients who had critical results and found that diagnostic clinicians documented the time the ordering provider was notified in only 25 (83 percent) of the records.

Documentation of Treatment Actions. VHA requires ordering providers to document in the medical record patient notification and treatment actions in response to critical test results. We reviewed the medical records of 30 patients who had critical results and found documented evidence of patient notification and follow-up actions in only 25 (83 percent) of the records.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider. We reviewed the medical records of 20 patients who had normal results and found that

[3] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009. All references to VHA requirements in this section refer to this directive.

only 13 of the records contained documented evidence that the facility had communicated the results to the patients.

Recommendations

6. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

7. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

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

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We identified the following areas that needed improvement.

PPE. The American Society of Health-System Pharmacists specifies that gowns worn during the compounding of hazardous drugs be disposed of immediately upon removal. Although pharmacy personnel wore protective gowns while compounding medications, the gowns were removed and hung on the wall of the compounding room for reuse during the day.

Work Practice. The JC requires that facilities separate clean and dirty items. We observed that nursing staff placed dirty chemotherapy supplies in a containment bag with clean chemotherapy supplies.

Recommendations

9. We recommended that protective gowns worn during the hazardous drug compounding process be disposed of immediately upon removal.

10. We recommended that processes be strengthened to ensure that nursing staff who administer chemotherapy medications separate clean and dirty supplies during chemotherapy administration.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected two inpatient medical units and interviewed two employees. We identified no deficits in either the inspections or staff interviews. However, we identified the following areas that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[5] with MDRO and their families receive education on infection prevention strategies, such as hand washing and the proper use of PPE. We reviewed 27 medical records and found that only 14 of the records had documented evidence of MDRO education.

Employee Training. The JC requires that facilities conduct a risk assessment to determine the need for staff education. The facility's most recent risk assessment stated that staff education was indicated for all employees during orientation and annually thereafter. We reviewed 52 employee training records to determine whether MDRO education had been provided in accordance with the risk assessment. We found that only nine (17 percent) of the records reviewed had documentation of annual MDRO education.

Recommendations

11. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

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

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the surgical, medicine, medical intensive care, rehabilitation, and mental health units; the CLC; the

[5] Colonization is the presence of bacteria in the body without causing clinical infection.

emergency room; a primary care and an audiology clinic; nuclear medicine; and general and interventional radiology. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

IC. If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 25 employee training records and determined that only 17 designated employees had the required annual fit testing.

Radiology. OSHA requires that the facility implement procedures for periodically inspecting the integrity of radiation shields and aprons. The facility does not maintain a master list of all aprons and shields; therefore, staff were unable to verify annual inspection of all aprons and shields.

The Radiation Safety Officer requires radiation safety training annually. We reviewed five Radiology Service employee training records and determined that one had the required annual radiation safety training documented.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. We found unsecured patient information outside patient rooms on the medical intensive care unit.

Recommendations

13. We recommended that annual N95 respirator fit testing and radiation safety training be completed by designated employees and documented.

14. We recommended that a system be developed to verify annual inspection of radiation shields and aprons.

15. We recommended that processes be strengthened to ensure that confidential patient information in the medical intensive care unit is secured.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents.

VHA requires that each facility have a policy mandating the membership and responsibilities of a CRC or its equivalent.[6] The facility had a CRC but no policy until March 3, 2011. We found the policy acceptable; therefore, we made no recommendation. However, we identified the following area that needed improvement.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review.[7] We found that two services did not provide the required medical record reviews and that medical record reviews did not include all of the required components. For example, we found that until February 2011, the facility did not review outpatient encounter notes, progress notes, or progress note addendums.

Recommendation

16. We recommended that all services provide the required medical record reviews and that processes be strengthened to ensure that all required components are included.

Follow-Up on CPR and ACLS Training and Certification

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with CPR and ACLS certification for clinically active staff. The facility had implemented a tracking system to monitor CPR and ACLS certifications, and status reports were forwarded to the appropriate service chiefs for action. Although, monitoring for staff compliance with certifications occurred monthly, the facility failed to ensure staff maintained current certifications. During the past year, compliance was below acceptable levels; however, when we were onsite, the facility reported current compliance at approximately 96 percent.

Recommendation

17. We recommended that clinically active staff maintain current CPR and/or ACLS certification.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 13–20, for the full text of the Directors' comments.) We consider Recommendations 1, 6, 9, 10, 11, 15, and 16 closed. We will follow up on the planned actions for the open recommendations until they are completed.

[6] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Facility Profile[8]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	16	
Community Based Outpatient Clinics	Altus, OK Ardmore, OK Blackwell, OK Enid, OK Konawa, OK Lawton, OK Wichita Falls, OK	
Veteran Population in Catchment Area	199,244 (FY 2011 projected)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	159	
• **CLC/Nursing Home Care Unit**	33	
• **Other**	0	
Medical School Affiliation(s)	University of Oklahoma College of Medicine	
• **Number of Residents**	105	
	Current FY (through December 2010)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$375	$398
• **Medical Care Expenditures**	$100	$398
Total Medical Care Full-Time Employee Equivalents	1,734.9	1,724.8
Workload:		
• **Number of Station Level Unique Patients**	34,312	55,383
• **Inpatient Days of Care:**		
o **Acute Care**	11,056	45,794
o **CLC/Nursing Home Care Unit**	2,120	8,569
Hospital Discharges	1,572	6,556
Total Average Daily Census (including all bed types)	147.1	152.2
Cumulative Occupancy Rate (in percent)	76.6	79.3
Outpatient Visits	118,498	504,277

[8] All data provided by facility management.

Follow-Up on Previous Recommendation			
Recommendation	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure clinically active staff have CPR or ACLS training and current certification.	Compliance fell below acceptable levels during the past year; however, for March 2011 compliance was at approximately 96 percent.	N	Y (see page 8)

VHA Satisfaction Surveys

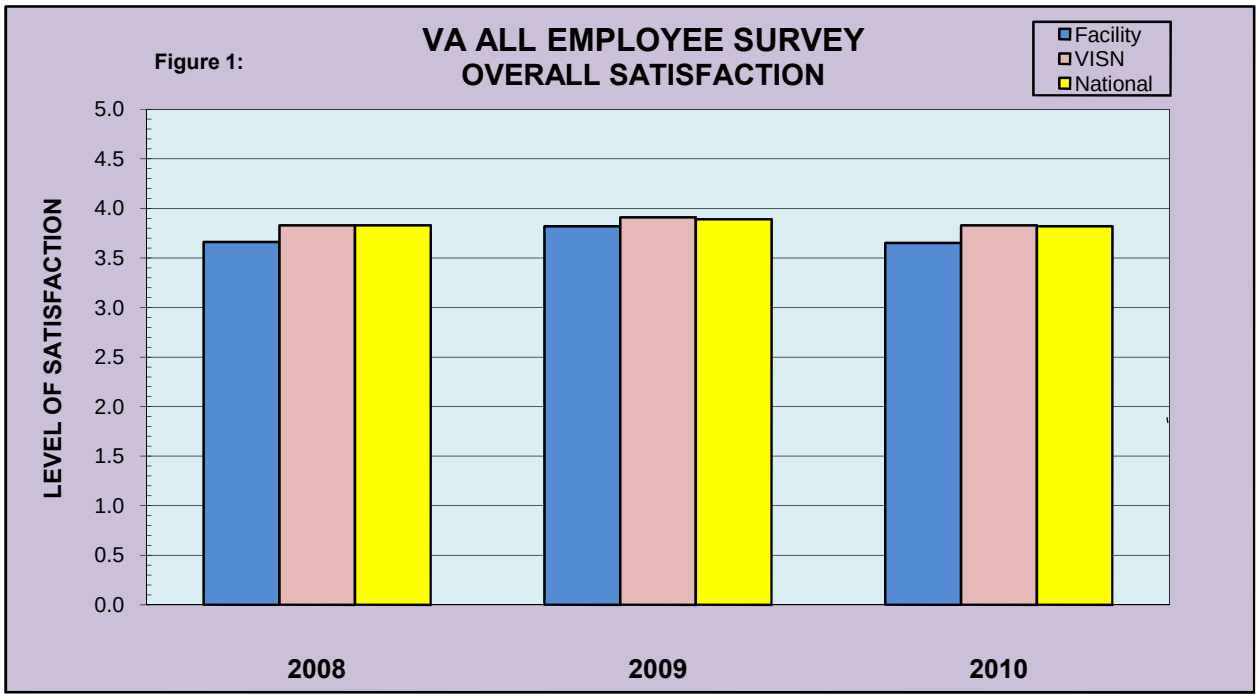
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	62.0	67.7	56.9	64.7	39.7	47.3	47.5	43.6
VISN	66.1	64.6	63.1	61.8	53.1	54.3	54.6	50.8
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[9] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.79	8.73	16.96	20.11	21.08	16.98
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[9] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 21, 2011

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

Subject: **CAP Review of the Oklahoma City VA Medical Center, Oklahoma City, OK**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed the response from the Oklahoma City VA Medical Center and concurs with the response.

2. If you have any questions, please contact Adrienne Riesenbeck, Director, Office of Performance and Quality, at (405) 456-3146.

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

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 21, 2011

From: Director, Oklahoma City VA Medical Center (635/00)

Subject: **CAP Review of the Oklahoma City VA Medical Center, Oklahoma City, OK**

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

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I concur with the finding and recommendation of the OIG CAP Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Adrienne Riesenbeck, Director, Office of Performance and Quality, at (405) 456-3146.

(original signed by:)
David P. Wood, MHA, FACHE
Oklahoma City VAMC Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that FPPEs be initiated for all applicable physicians and that results be reported to SPICE.

Concur

Target date for completion: Complete

FPPE requests are initiated through the Credentialing Committee (PSB) for all applicable physicians, dentists, and mid-level providers. A tracking mechanism will be utilized to ensure all FPPE results are reported back to the Credentialing Committee and the Medical Staff Executive Committee (SPICE) as initially requested by the committee. FPPE was completed as appropriate for the staff identified as noncompliant by the OIG review team. The FPPE was reported to the SPICE Committee by April 21, 2011.

Recommendation 2. We recommended that processes be strengthened to ensure that adequate competency data is maintained in all physicians' profiles.

Concur

Target date for completion: July 1, 2011

OPPE criteria and data will be reviewed by the Credentialing Committee (PSB) to ensure adequate data is maintained in all physicians' profiles. The OPPE data will then be reviewed by the SPICE Committee with actions taken as appropriate.

Recommendation 3. We recommended that processes be strengthened to ensure that staff provide and document advance directive notification and screening at each inpatient admission.

Concur

Target date for completion: June 30, 2011

Following the OIG visit, a workgroup was convened by the Chief of Staff to ensure the facility's advance directive process is congruent with VA requirements. The workgroup will develop processes to ensure staff provide and document advance directive notification and screening at each inpatient admission. Random chart reviews will be completed and reported to the Safety and Performance Improvement Clinical Executive Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that all advance directives are scanned into the electronic medical record and that patient advance care planning progress notes are linked to the CWAD posting.

Concur

Target date for completion: June 30, 2011

Following the OIG visit, a workgroup was convened by the Chief of Staff to ensure the facility's advance directive process is congruent with VA requirements. The workgroup will develop processes to ensure all advance directives are scanned into the medical record and the patient advance care planning progress notes are linked to the CWAD posting. Random chart reviews will be completed and reported to the Safety and Performance Improvement Clinical Executive Committee.

Recommendation 5. We recommended that a copy of the completed advance directive document be provided to the patient.

Concur

Target date for completion: June 30, 2011

Following the OIG visit, a workgroup was convened by the Chief of Staff to ensure the facility's advance directive process is congruent with VA requirements. The workgroup will develop processes to ensure a copy of the completed advance directive document is provided to the patient. Random chart reviews will be completed and reported to the Safety and Performance Improvement Clinical Executive Committee.

Recommendation 6. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

Concur

Target date for completion: Complete

Immediately following the OIG review, staff were re-educated on the reporting of crticial test results to the provider. Facility specified critical results were also reviewed with the lab staff. A random review of critical test results will be conducted to ensure the time critical results were communicated to the provider is documented. Compliance rate will be reported to the Patient Safety Goals Committee.

Recommendation 7. We recommended that ordering providers document patient notification and treatment actions in response to critical results.

Concur

Target date for completion: June 30, 2011

A taskgroup was convened to address documentation of patient notification and treatment actions in response to critical results. Random chart reviews will be conducted to monitor compliance.

Recommendation 8. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: June 30, 2011

A taskgroup was convened to address the timely notification of normal test results in accordance with VA requirements. The notification will be documented in the medical record. Random chart reviews will be conducted to monitor compliance.

Recommendation 9. We recommended that protective gowns worn during the hazardous drug compounding process be disposed of immediately upon removal.

Concur

Target date for completion: Complete

The Pharmacy standard operating procedure (SOP) was revised to include "gown is to be discarded when removed." Pharmacy staff responsible for compounding chemotherapeutic agents were educated on the revised SOP at the Pharmacy Service Staff Meeting on March 23, 2011. Random observations will be conducted to ensure staff are compliant with the revised SOP requirements.

Recommendation 10. We recommended that processes be strengthened to ensure that nursing staff who administer chemotherapy medications separate clean and dirty supplies during chemotherapy administration.

Concur

Target date for completion: Complete

Following the OIG review, a process was put in place to have a second bag supplied with chemotherapeutic agents. The used chemotherapy bag will be placed in the bag, which is labeled as "chemotherapy," and disposed of appropriately. NM/designee will randomly monitor compliance to ensure clean and dirty supplies are kept separate during chemotherapy administration.

Recommendation 11. We recommended that infection prevention strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target date for completion: Complete

Staff nurses were re-educated by April 5, 2011 regarding the need to provide and document MDRO patient education. Nurse Managers are completing random monitoring of documentation of MDRO education with immediate follow-up provided as appropriate. The rate of compliance with documentation of education will be reported by the MDRO Prevention Coordinator to the Patient Safety Goals Committee, the Infection Control Committee, and Nursing Leadership.

Recommendation 12. We recommended that employees receive annual MDRO education and that the training be consistently documented.

Concur

Target date for completion: August 31, 2011

All staff reviewed by the OIG review team for MDRO education now have documentation of required education. All service chiefs were notified of the requirements for annual MDRO staff education on March 7, 2011. Service chiefs are required to report the rate of compliance with annual MDRO staff education, and the rate of compliance is reported to Infection Control Committee and rolled up to SPICE Committee. The current compliance rate is 95%.

Recommendation 13. We recommended that annual N95 respirator fit testing and radiation safety training be completed by designated employees and documented.

Concur

Target date for completion: August 31, 2011

All staff reviewed by the OIG for N95 respirator fit testing are now compliant. A process was developed to ensure staff and service chiefs are notified of the requirement for N95 respirator fit testing. New personnel will be fit tested on entry to the facility. The compliance rate for N95 respirator fit testing will be reported monthly to the EOC Committee. Fit testing for the required staff is ongoing. The facility compliance rate is currently 82%. Completion of fit testing for required staff is expected by August 31, 2011. Radiation Safety Training has been completed for 100% of radiology staff. A process was developed to ensure staff and service chiefs are notified of the annual requirement for Radiation Safety Training.

Recommendation 14. We recommended that a system be developed to verify annual inspection of radiation shields and aprons.

Concur

Target date for completion: June 30, 2011

An inventory of all services utilizing lead aprons in underway. A master list of all lead aprons will be developed, and will be utilized to ensure all lead aprons are inspected annually. In addition, local policy will be updated to require the Physical Science Technician's signature approval prior to the purchase of any lead aprons, and disposal of lead aprons can only be done by the Physical Science Technician. The master list will then be updated to include lead aprons purchased and destroyed.

Recommendation 15. We recommended that processes be strengthened to ensure that confidential patient information in the medical intensive care unit is secured.

Concur

Target date for completion: Complete

Notebooks containing confidential patient information are now kept at the nurses' station. The Nurse Manager or designee will conduct random observations to ensure patient confidential information is kept in a secure location. Privacy issues are also assessed and addressed during weekly EOC rounds.

Recommendation 16. We recommended that all services provide the required medical record reviews and that processes be strengthened to ensure that all required components are included.

Concur

Target date for completion: Complete

The two services requiring reporting of medical record reviews reported medical record reviews to the Medical Records Committee on April 14, 2011. Services that do not report medical record reviews to Medical Records Committee are reported to the Medical Executive Committee (SPICE Committee). The SPICE Committee chair will ensure reviews are submitted to Medical Records Committee.

Recommendation 17. We recommended that clinically active staff maintain current CPR and/or ACLS certification.

Concur

Target date for completion: August 31, 2011

Local facility policy was updated to include consequences for staff who do not obtain/maintain their certification. Monitoring of the completion of ACLS/BLS certification with compliance rate reported to the CPR Committee and Medical Center Leadership. The facility compliance rate is currently 96%.

OIG Contact and Staff Acknowledgments

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U.S. Senate: Tom Coburn, James M. Inhofe
U.S. House of Representatives: Tom Cole, James Lankford, Frank Lucas

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