Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01107-243

Combined Assessment Program Review of the VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania

August 2, 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

AD	advance directive
BSC	bio-safety cabinet
C&P	credentialing and privileging
CAP	Combined Assessment Program
CSC	Customer Service Committee
ED	emergency department
EMR	electronic medical record
EN	enteral nutrition
EOC	environment of care
facility	VA Pittsburgh Healthcare System
FY	fiscal year
JC	Joint Commission
OIG	Office of Inspector General
PR	peer review
PUMA	Physician Utilization Management Advisor
QM	quality management
RN	registered nurse
SDS	same day surgery
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, PA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of April 11, 2011.

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

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

The facility's reported accomplishment was the mental health unit's sensory modulation room, which reduced assaults by decreasing external stimulation for aggressive patients.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that:

- Peer Review (PR) Committee meeting minutes document actions taken for Level 2 and 3 PRs.
- The Director's approval is requested and obtained for PR extensions.
- Cases that do not meet utilization management (UM) criteria are referred to a Physician UM Advisor.
- UM data are reported.
- Providers assess and document all required elements prior to performing moderate sedation.
- Resuscitation episodes are analyzed and benchmarked.
- All required medical record review components are collected, analyzed, and reported.
- Patient complaint data are trended and analyzed by the Customer Service Committee and that minutes are reviewed by a senior-level committee.

Registered Nurse Competencies: Document competencies, actions taken when deficiencies are identified, and competency evaluator qualifications. Specify competency validation methods.

Environment of Care: Complete and monitor N95 respirator fit testing. Ensure privacy for women patients in the same day surgery unit.

Medication Management: Ensure staff safely compound and handle hazardous drugs.

Coordination of Care: Strengthen advance directive notification and documentation processes.

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 eight activities:

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

The review covered facility operations for FY 2010 and FY 2011 through April 11, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined*

Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, Report No. 08-02871-52, January 13, 2009). (See Appendix B for further details.) The facility had a repeat finding in the area of patient complaint analysis and reporting.

During this review, we also presented crime awareness briefings for 350 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Sensory Modulation Room

To address escalating and aggressive patient behavior while respecting patient privacy, a sensory modulation room was designed and implemented on a mental health unit. The room was based on the concept of daycare timeout stations. The design decreases external stimuli and promotes relaxation using aromatherapy, massage pillows, weighted blankets, clay, squeeze balls, reading materials, and other audio-visual relaxation items. Following implementation of the sensory modulation room, the assault rate on the mental health unit dropped dramatically (by 50 percent).

Results

Review Activities With Recommendations

QM

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

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

PR. VHA requires that the PR Committee receive feedback regarding actions taken for Level 2 or 3 PRs.[1] We reviewed PR Committee meeting minutes and did not find evidence of

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

this feedback. VHA also requires that extensions be requested from and approved by the facility Director when PR completion will exceed 120 days. We did not find extension requests or approvals for the four PRs that required more than 120 days to complete.

UM. VHA requires that facilities have a designated and trained PUMA who reviews all cases not meeting UM criteria.[2] We did not find evidence that the facility had designated and trained a PUMA to review cases. In addition, VISN 4 requires that facilities analyze and report selected UM data; however, we found that the facility did not report all the required UM data. For example, the facility did not include analysis of the acute bed day of care rate and the number of, and reasons for, diversion.

Moderate Sedation. VHA requires providers to assess patients and document assessment findings prior to performing moderate sedation.[3] We did not find documented evidence that providers assessed patients for all required elements. For example, we did not find documentation of airway assessment in 4 of the 10 EMRs reviewed.

Review of Resuscitation and Its Outcomes. VHA requires facilities to track, trend, analyze, and benchmark for specific areas of resuscitation review.[4] We found that not all required resuscitation data had been reported and that data was not benchmarked. For example, data was not reported for erroneous or deficient resuscitation-related procedures and unavailable or malfunctioning equipment.

Medical Record Review. VHA requires facilities to conduct EMR reviews that include specific components.[5] We found that EMR quality reviews did not include all of the required components. For example, the facility did not gather, analyze, and report data on discharge summaries, operative reports, and history and physical notes.

Patient Complaints. VHA policy requires that patient complaint and patient satisfaction data be collected, trended, and analyzed and included, along with other quality

[2] VHA Directive 2010-021, *Utilization Management Program,* May 14, 2010.
[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[4] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

improvement data, for discussion in the appropriate facility committees and forums.[6] We found that CSC meeting minutes did not include trending and analyses of patient complaint data and were not reviewed by a senior-level committee. This was a repeat finding from the previous CAP review.

Recommendations

1. We recommended that processes be strengthened to ensure that PR Committee meeting minutes document actions taken for Level 2 and 3 PRs.

2. We recommended that processes be strengthened to ensure that all PRs that exceed 120 days have extensions requested from and approved by the facility Director.

3. We recommended that the facility designate and train a PUMA and strengthen processes to ensure that cases that do not meet UM criteria are referred to the PUMA.

4. We recommended that processes be strengthened to ensure that all required UM data elements are reported.

5. We recommended that processes be strengthened to ensure that providers assess and document all required elements prior to performing moderate sedation.

6. We recommended that processes be strengthened to ensure that data related to resuscitation episodes are analyzed and benchmarked.

7. We recommended that processes be strengthened to ensure that all required medical record review components are collected, analyzed, and reported.

8. We recommended that patient complaint data be trended and analyzed by the CSC and that CSC meeting minutes be reviewed by a senior-level committee.

RN Competencies

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

We reviewed facility policies, interviewed nurse managers, and reviewed initial and ongoing competency assessment

[6] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

and validation documents for 12 RNs. We identified the following areas that needed improvement.

Facility Competency Validation Process. The JC requires that clinical staff are deemed competent to perform their job responsibilities and that the facility takes action when staff competency does not meet expectations. A competency validation policy or process is required for staff who provide patient care, treatment, or services. Assessment and validation of competencies should be done when the RN is hired and then at least every 3 years. We found that the facility did not follow their competency validation policy. Core and unit/position-specific competencies were identified, but the required documentation of completed competencies was not consistently available. Additionally, although the facility had a process to take action to correct identified deficiencies, we found inconsistent evidence that actions were taken.

Competency Validation Documentation. The JC requires that nursing personnel are competent to function in their assignments. Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. None of the 12 RN competency folders contained sufficient evidence that core and unit/position-specific competencies had been validated. All of the folders had incomplete or missing validation of documentation or outdated forms.

Competency Validation Methods. The JC requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. We found that validation methods for some competencies were not specified for the skill being assessed and validated.

Competency Validation by Qualified Individuals. The JC requires that competency is assessed and validated by an individual with the appropriate education, experience, or knowledge related to the skills being reviewed. Facility policy did not specify the qualifications required for individuals who perform competency assessment and validation.

Recommendations

9. We recommended that the established policy for documentation of completed competencies be followed and that responsible staff consistently document actions taken when competency deficiencies are identified.

10. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

11. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

12. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

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.

At the University Drive division, we inspected medical (6W), surgical (4W), and medical intensive care units; the podiatry clinic; the ear, nose, and throat clinic; the SDS unit; and the ED. At the Highland Drive division, we inspected the locked mental health (1–3W) unit. At the Heinz division, we inspected the palliative care (3A) and community living center (3B) units. We identified the following conditions that needed improvement.

N95 Respirator Fit Testing. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 15 employee training records and determined that 6 designated employees did not have the required annual fit testing.

SDS Unit Privacy. VHA requires that women patients wearing examination gowns have access to gender-specific restrooms without going through public areas.[7] All SDS patients were required to cross a busy hallway to access the gender-specific restrooms and changing areas. Therefore, patient privacy was not being maintained.

[7] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.

Recommendations

13. We recommended that N95 respirator fit testing be completed annually and that compliance be monitored.

14. We recommended that the facility ensure privacy for women patients in the SDS unit.

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 area that needed improvement.

Safe Work Practices. The American Society of Health-System Pharmacists requires safe handling of hazardous drugs to minimize contamination and ensure staff and patient safety. All items needed for compounding drugs must be gathered before beginning work, and the BSC should not be exited once compounding has begun. However, if it is necessary to exit and re-enter the BSC, contaminated outer gloves must be removed before touching supplies, and new outer gloves must be donned before re-entering the BSC. We observed a pharmacy staff member exit the BSC without removing outer gloves, gather additional supplies, and re-enter the BSC without donning new outer gloves.

Recommendation

15. We recommended that pharmacy staff who compound chemotherapy medications remove outer gloves before exiting the BSC and don new outer gloves before re-entering the BSC.

Coordination of Care

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

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

AD Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding

their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[8] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the EMRs of 20 patients and found that none of the EMRs contained evidence of all components of written notification.

Recommendation

16. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the EMR.

Review Activities Without Recommendations

EN Safety

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

We reviewed policies and documents related to EN and patients' EMRs. While conducting the EOC review, we also inspected areas where EN products were stored, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Management of Workplace Violence

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

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

Physician C&P

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

We reviewed 15 C&P files and profiles and meeting minutes during which discussions about the physicians took place.

[8] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 15–22, for the full text of the Directors' comments.) We consider Recommendations 2, 14, 15, and 16 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	4	
Community Based Outpatient Clinics	Monaca, PA St. Clairsville, OH Uniontown, PA Washington, PA Greensburg, PA	
Veteran Population in Catchment Area	433,274	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	237	
• **Community Living Center/Nursing Home Care Unit**	262	
• **Other**	84	
Medical School Affiliation(s)	University of Pittsburgh Medical School, Graduate Medical Education	
• **Number of Residents**	950	
	Current FY (through January 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$436.6	$422.2
• **Medical Care Expenditures**	$289.8	$422.0
Total Medical Care Full-Time Employee Equivalents	2,295.5	2,258.2
Workload:		
• **Number of Station Level Unique Patients**	36,912 (through December 2010)	60,141
• **Inpatient Days of Care:**		
o **Acute Care**	13,844	42,112
o **Community Living Center/Nursing Home Care Unit**	25,553	74,788
Hospital Discharges	2,955	8,741
Total Average Daily Census (including all bed types)	474.53	475.09
Cumulative Occupancy Rate (in percent)	81.4	81.5
Outpatient Visits	141,831 (through December 2010)	561,997

[9] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure that CSC minutes are reviewed by a senior-level committee and that patient satisfaction data is tracked, trended, and analyzed.	Quarterly round table discussions with leadership and service line vice presidents were implemented, and veterans were invited to strategic planning sessions. Satisfaction data is presented at the Executive Leadership Board. The Veteran Service Council was disbanded.	N	Y (see pages 3–4)
2. Ensure that a policy is developed regarding the copying and pasting of text in the EMR and that a process to monitor copying and pasting in the EMR is implemented.	Facility policy was developed. Monitoring criteria for copying and pasting were established, and reports are provided to the continuous readiness team.	Y	N
EOC			
3. Ensure all Environmental Management Service employees receive the required *Clostridium difficile* environmental cleaning and infection control training.	In 2009 and 2010, Environmental Management Service staff received annual infection prevention training, which included environmental cleaning for *Clostridium difficile*.	Y	N
4. Address general cleanliness in the medical intensive care unit, secure and properly seal construction access, and secure access to soiled utility rooms.	All items were addressed by the Chief of Environmental Management Service and continue to be maintained.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Coordination of Care			
5. Ensure that discharge summaries are completed and that they are consistent with the discharge instructions provided to patients.	Discharge instructions are provided and verified with post-discharge telephone calls.	Y	N
Medication Management			
6. Establish a policy to resolve the conflict between the EMR template and the policy concerning PRN[10] pain assessment and documentation.	The EMR pain template was revised immediately following the 2008 CAP review.	Y	N
7. Revise the Bar Code Medication Administration policy to reflect the current practice.	Facility policy was revised.	Y	N
Emergency/Urgent Care Operations			
8. Ensure all inter-facility transfer documentation complies with VHA policy.	A review by the ED medical director demonstrated more than 90 percent compliance.	Y	N
9. Ensure critical equipment monitoring is performed and documented, as required by facility policy.	The process for defibrillator checks was reviewed with all ED staff and is covered annually in mandatory review sessions.	Y	N
10. Ensure nursing staff point-of-care competency certification documentation is complete.	ED nursing staff completed competency certification during 2009 and 2010 mandatory reviews.	Y	N

[10] PRN is derived from a Latin phrase "pro re nata" and means "as needed."

VHA Satisfaction Surveys

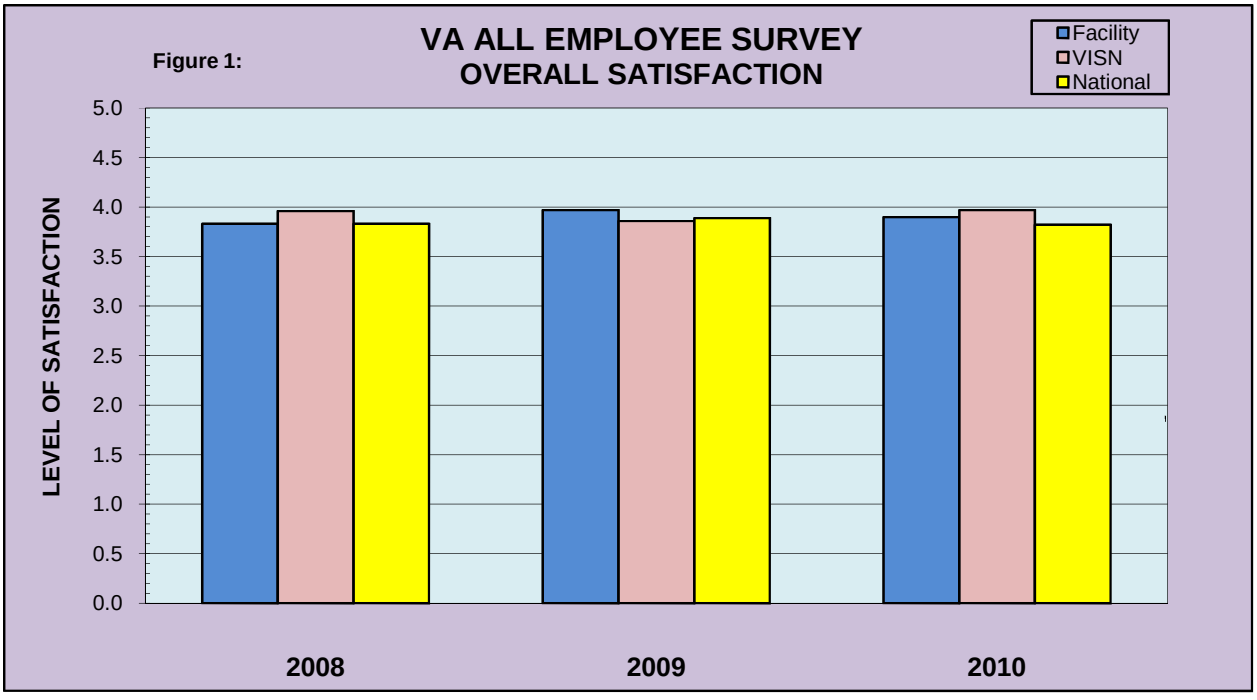
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

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	61.8	68.0	71.7	63.0	61.2	63.3	60.0	66.8
VISN	62.7	65.5	65.3	63.0	59.5	61.4	60.1	61.8
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[11] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	13.79	9.83	14.49	20.93	23.52	16.91
VHA	13.31	9.73	15.08	20.57	21.71	15.85

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2011

From: Director, VISN 4 (10N4)

Subject: **CAP Review of the VA Pittsburgh Healthcare System, Pittsburgh, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

I have reviewed the draft report of the VA Pittsburgh Healthcare System. I concur with the findings and implemented plans.

MICHAEL A. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 24, 2011

From: Director, VA Pittsburgh Healthcare System (646/00)

Subject: **CAP Review of the VA Pittsburgh Health Care System, Pittsburgh, PA**

To: Director, VISN 4 (10N4)

Listed below are the completed improvement actions for the sixteen recommendations received from the Office of the Inspector General for the April 2011 Combined Assessment Program review.

Terry Gerigk Wolf, FACHE

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 processes be strengthened to ensure that PR Committee meeting minutes document actions taken for Level 2 and 3 PRs.

Concur Target Date for Completion: November 1, 2011

The Service Chief section of the "Clinical Occurrence Review Form" has been expanded to include date, discussion, and actions taken for Peer Review Levels 2 and 3. This review form is used by the Peer Review Committee for case discussions and content of minutes. All cases designated as a level 2 or 3 will be reviewed over a four month time frame to insure that the additional information is completed. Committee minutes for the same time frame will be reviewed to determine whether or not this information was used in the case discussions. Results will be presented at the November meeting of the Executive Leadership Board.

Recommendation 2. We recommended that processes be strengthened to ensure that all PRs that exceed 120 days have extensions requested from and approved by the facility Director.

Concur Target Date for Completion: Completed

Pending peer reviews are evaluated for timeliness by the Nurse Clinical Reviewer on a weekly basis. Fourteen days prior to the 120 day requirement the Chief of Staff will send an extension request to the Medical Center Director. For those cases in which an extension is not granted, the Chief of Staff will convene a special session of the Peer Review Committee in order to close the review process. Medical Center Policy and Procedure "Peer Review for Quality Management" has been revised to reflect this change.

Recommendation 3. We recommended that the facility designate and train a PUMA and strengthen processes to ensure that cases that do not meet UM criteria are referred to the PUMA.

Concur Target Date for Completion: November 1, 2011

Sixteen providers have been designated as reviewers and have completed PUMA training. This group of providers represents all physician specialties as follows: medical specialty – 5, surgical specialty – 4, behavioral health – 5, and critical care – 2. These providers are reviewing all cases referred to them. Over a four month period all cases not meeting criteria will be tracked to ensure that these were referred to the appropriate PUMA. Minutes of the Utilization Review Committee will be reviewed for discussion of

PUMA case referrals and associated actions. Progress report will be presented at the November meeting of the Executive Leadership Board.

Recommendation 4. We recommended that processes be strengthened to ensure that all required UM data elements are reported.

Concur Target Date for Completion: November 1, 2011

In conjunction with the VISN "Utilization Management/Review Policy" the following mandatory reporting variables are collected, analyzed, trended, and reported quarterly to the Executive Leadership Board: number and percentage of admissions and continued stay days meeting criteria in Medicine, Surgery, and Behavioral Health; reasons for days not meeting criteria; recommended level of care when criteria not met; analysis of physician approval and/or denials of the number of patients not meeting criteria during the first level of review; acute bed days of care (BDOC) rate; and, number of diversions and reasons for diversion. A four month review of utilization review data analysis will be conducted to ensure that all elements as identified have been analyzed and appropriately trended. This will include a monthly review of data displays, UM Committee minutes, and reports presented to Executive Leadership Board. A progress report will be presented at the November meeting of the Executive Leadership Board.

Recommendation 5. We recommended that processes be strengthened to ensure that providers assess and document all required elements prior to performing moderate sedation.

Concur Target Date for Completion: November 1, 2011

Assessment and documentation requirements prior to administration of conscious sedation were reviewed with all appropriate providers. Moderation Sedation Committee will perform case reviews from each area using moderate sedation. Data analysis will be tracked and trended by provider. Action plans will be required for cases that are found to be deficient. A progress report, including four months of data analysis, will be presented at the November meeting of the Executive Leadership Board.

Recommendation 6. We recommended that processes be strengthened to ensure that data related to resuscitation episodes are analyzed and benchmarked.

Concur Target Date for Completion: November 1, 2011

In conjunction with the requirements in the VHA Directive for Oversight and Monitoring of Cardiopulmonary Resuscitation Events, the following elements will be added to the current aggregate analysis: errors in technique or procedures during resuscitation efforts, appropriateness of interventions against the standard of care, clinical issues contributing to the resuscitation event, delay in initiating resuscitation, and, malfunctioning equipment. Aggregate analysis and identification of trends and/or patterns will be done monthly by the CPR Committee. A progress report will be provided at the November meeting of the Executive Leadership Board.

Recommendation 7. We recommended that processes be strengthened to ensure that all required medical record review components are collected, analyzed, and reported.

Concur Target Date for Completion: November 1, 2011

Each week a delinquent list for history and physicals and discharge summaries will be sent to the respective Service Line Vice President. Daily a list of delinquent operative reports will be sent to the Surgical Specialty Service Line. Provider specific information is included in each report. A monthly medical record delinquent summary is provided to the Clinical Informatics (Medical Record) Committee. Trends by service line will be identified. Data will be trended over time. Each quarter a delinquent summary report will be provided to the Medical Executive Board. A four month review of this process will be conducted. Each month a review of the outlined process will be completed to determine compliance. Minutes of Clinical Informatics and Medical Executive Board content will be included in the review. A progress report will be provided at the November meeting of the Executive Leadership Board.

Recommendation 8. We recommended that patient complaint data be trended and analyzed by the CSC and that CSC meeting minutes be reviewed by a senior-level committee.

Concur Target Date for Completion: November 1, 2011

The monthly Business Manager meeting serves as the Customer Service Council. Effective June 20, 2011 complaint data are sent for review and action as warranted. These minutes are reviewed by the Executive Leadership Board. A monthly review of data displays for patient complaint data and discussion in the Business Manager minutes will be completed for a four month time frame. A progress report will be presented at the November meeting of the Executive Leadership Board.

Recommendation 9. We recommended that the established policy for documentation of completed competencies be followed and that responsible staff consistently document actions taken when competency deficiencies are identified.

Concur Target Date for Completion: November 1, 2011

Competency Assessment Policy is being revised to specifically identify processes for validating, tracking, monitoring, and documenting registered nurse competencies. The process will include a mechanism to ensure all competency deficiencies are addressed. All staff that validates competencies will provide written communication of all deficiencies to nurse managers with request for return signatures. This notice will include: name, date of competency, notice for action/plan remediation, and, the date by which the action must be completed. Deficiency notifications will be sent to the Department of Nursing Education where monitoring and follow-up will be tracked. Monthly monitors will track nurse manager compliance. Monthly reviews of this tracking process will be validated over a four month period. A progress report will be provided at the November meeting of the Executive Leadership Board.

Recommendation 10. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

Concur Target Date for Completion: November 1, 2011

Competency Assessment Program is being developed to ensure consistent tracking, monitoring and documentation of competencies. Competency Assessment Checklists are being standardized. Registered Nurse Competency Assessment Program will specifically detail how identification; verification/validation; monitoring/tracking; and, annual reporting will be accomplished. Nurse Educators will serve as points of contact for each division/service. Each will work in collaboration with the Associate Chief Nurse, Vice President, and/or the Nurse Manager to monitor and track competency compliance and completion. The Nursing Education Department will provide overall coordination of the program. A competency database is being created in SharePoint for all nursing leaders. Competencies will be able to be tracked and monitored from this site. A status report will be provided at the November meeting of the Executive Leadership Board.

Recommendation 11. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

Concur Target Date for Completion: November 1, 2011

The unit/position specific competency assessment form is being revised to include the following validation methods: demonstration, observation, simulation, written test, or verbalization. A validation process is being established in order to ensure all documentation has been completed. The validation process will require the signatures of the individual assessing the competency, nurse educator, and nurse manager. Over a four month time frame, registered nurse competencies completed each month will be reviewed for the documentation of the method of validation. A progress report will be given at the November meeting of the Executive Leadership Board.

Recommendation 12. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

Concur Target Date for Completion: November 1, 2011

Nurse Managers will identify the qualifications required for all staff who participates in the competency validation process for registered nurses. Qualifications will ensure that staffs that assess and validate competencies have the corresponding education, knowledge, skill, and experience commensurate with the skill being validated. This will be reflected in the new Competency Assessment Policy. A progress report will be provided at the November meeting of the Executive Leadership Board.

Recommendation 13. We recommended that N95 respirator fit testing be completed annually and that compliance be monitored.

Concur Target Date for Completion: November 1, 2011

A Respiratory Protection Program has been implemented that is in accordance with all OSHA requirements. Fit testing and training sessions are conducted throughout the year by an independent contractor. During interim periods fit testing is done by Industrial Hygiene Staff. Each month, fit test records are compared to Service Line staff rosters to ensure that employees who require respiratory protection have been fit tested. Powered air purifying respirators (PARS) are used to supplement N-95 respirators for those with facial hair or who fail fit testing. PARS are located on the inpatient units and the emergency department. PARS are also used by those employees who for whatever reason are unable to wear a standard N-95 respirator. All employees who currently require respiratory protection have been fit tested. A monthly review will be completed for a four month time frame of fit-testing for randomly selected high risk areas. A progress report will be presented at the November meeting of the Executive Leadership Board.

Recommendation 14. We recommended that the facility ensure privacy for women patients in the SDS unit.

Concur Target Date for Completion: Completed

Room 9W107, with private bathroom, was designated as the secure and private female changing room for the Same Day Surgery Unit. All female Veterans are required to wear hospital gown, robe, and slippers. By the end of FY11, the new SDS unit will open. The new design includes individual patient bays for privacy.

Recommendation 15. We recommended that pharmacy staff who compound chemotherapy medications remove outer gloves before exiting the BSC and don new outer gloves before re-entering the BSC.

Concur Target Date for Completion: Completed

All pharmacists and pharmacy technicians competent to compound chemotherapy and other hazardous medications were provided a copy of the ASHP Guidelines for Handling Hazardous Drugs. The Pharmacy Program Leader discussed with staff the specific guidelines pertaining to the appropriate use of gloves and necessity to remove outer gloves prior to removing hands from the biological safety cabinet in order to prevent chemotherapy and other hazardous medications from contaminating surrounding areas. Gloves must then be reapplied and sterilized prior to returning hands to the biological safety cabinet. A quick reference gloving guide was developed and posted for staff reference.

Recommendation 16. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the EMR.

Concur Target Date for Completion: Completed

The following has been added to assessment templates in the electronic medical record: “Patient verbalized they received written notification regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document

their treatment preferences in an advanced directive." This addition also includes an entry to indicate a patient's level of consciousness or cognitive status. In those cases in which there is an altered level of consciousness, the information is reviewed with the next of kin and/or guardian. The template provides for the entry of this information. The assessment templates include: psychosocial assessment, history and physical, medical student history and physical, preoperative history and physical consultation, history and physical short version, and nursing admission assessment. This is a forced field entry in each of the templates.

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