
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 11-01294-244**

# Combined Assessment Program Review of the VA Maine Healthcare System Augusta, Maine

**August 3, 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

| | |
|---|---|
| C&P | credentialing and privileging |
| CAP | Combined Assessment Program |
| COC | coordination of care |
| ED | emergency department |
| EN | enteral nutrition |
| EOC | environment of care |
| facility | VA Maine Healthcare System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| OIG | Office of Inspector General |
| PRC | Peer Review Committee |
| PSB | Professional Standards Board |
| QM | quality management |
| RN | registered nurse |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the VA Maine Healthcare System, Augusta, ME

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management. We conducted the review the week of May 9, 2011.

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

- Management of Workplace Violence
- Medication Management
- Registered Nurse Competencies

The facility's reported accomplishments are a specialized hospice and palliative care program, becoming a tobacco-restricted campus, and an outreach and educational program for homeless veterans.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Strengthen processes to ensure that quality management committees document and track the implementation and closure of action items related to quality of care data. Ensure that supervisors implement appropriate actions for individuals assigned Level 2 or Level 3 peer reviews and that they notify the Peer Review Committee upon completion of corrective actions. Analyze and trend outcomes data related to the use of reversal agents in conjunction with moderate sedation procedures. Strengthen processes to ensure that providers perform and document reviews of patients' organ systems, current medications, and current allergies prior to procedures requiring moderate sedation and that compliance be monitored.

*Physician Credentialing and Privileging:* Ensure that Focused Professional Practice Evaluations be completed for newly hired physicians.

*Environment of Care:* Complete annual bloodborne pathogens training, and monitor compliance.

*Coordination of Care:* Strengthen processes to ensure that patients who request information about advance directives receive that information. Ensure that the facility policy for management of advance care planning/advance directives is updated to be consistent with current Veterans Health Administration policy and that compliance with the updated policy be monitored.

*Enteral Nutrition Safety:* Ensure that enteral nutrition documentation includes all required elements.

## 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 objective of the CAP review is to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

## 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:

- COC
- 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 30, 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 Togus VA Medical Center, Augusta, Maine,* Report No. 07-03176-17, November 3, 2008). (See Appendix B for further details.) The facility had corrected 10 of the 11 findings from our previous review.

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 Accomplishments

**Hospice and Palliative Care Program**

The facility has a well developed, patient-centered Hospice and Palliative Care Program. The After Hours On-Call Community Hospice Support Program uses its own providers as primary points of contact for community hospice nurses caring for veterans. One of the highlights of this service is a weekly telephone conference with community nurses to discuss veterans' care management. The palliative care team consults with attending providers during the acute phases of care prior to transfer to the hospice unit. The program has received national recognition from the Center for Health Equity Research and Promotion for its pain control and bereavement counseling programs. In June 2011, the facility will open a newly constructed state-of-the-art 12-bed hospice unit.

**Tobacco-Restricted Campus**

On November 15, 2010, the facility became a tobacco-restricted campus. The Maine Tobacco Free Hospital Network, in conjunction with the American Cancer Society's Great American Smokeout®, presented the facility with a Gold Star Award for demonstrated leadership and progress toward adopting exemplary tobacco-free policies that protect the health of patients, staff, and the community.

**Homeless Veterans Program**

The facility has embraced a "no wrong door" philosophy to shape outreach and educational programming to meet the needs of homeless veterans. The homeless veterans' team has strong relationships with Maine's shelters and communicates regularly with the shelters to foster continued partnership in identifying homeless veterans eligible for Veterans Benefits Administration and VHA services. The homeless veterans' team has compiled comprehensive packets to educate both veterans and community providers about VA resources available to veterans.

# 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.

Action Item Tracking. VHA requires that QM data is analyzed and trended and action items are identified.[1] Once action items are determined, implementation of actions must be followed to completion. Committee minutes must include discussions about QM reviews and reflect tracking of issues to completion. We found that senior-level QM Committee, Moderate Sedation Committee, PRC, Medical Record Review Committee, and Special Care Unit Committee minutes did not consistently document and track the implementation and closure of action items.

Peer Review. VHA requires that the PRC receive written notification upon completion of corrective actions.[1] In all of the cases reviewed, we found that the PRC tracking log did not indicate follow-up of corrective actions, such as provider counseling, guideline review, and referral for service-specific peer review.

Moderate Sedation Reversal Agents. VHA requires facilities to monitor outcomes related to the use of moderate sedation, including the use of reversal agents.[2] Outcomes data must be systematically aggregated, trended, and analyzed. We found no evidence that nurse managers analyzed or trended outcomes data related to the use of reversal agents in conjunction with moderate sedation. This was a repeat finding.

Moderate Sedation Record Review. VHA requires providers to document a complete history and physical within 30 days prior to a procedure where moderate sedation will be used and to re-evaluate the patient immediately prior to sedation.[3] These evaluations must include an assessment of organ systems, current medications, and current allergies. We reviewed the medical records of 10 patients who underwent selected procedures using moderate sedation and found that 8 of the pre-sedation evaluations did not contain a review of organ systems or current medications and that 2 did not

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Directive 2006-023.

have a review of current allergies.

**Recommendations**

**1.** We recommended that processes be strengthened to ensure that all committees document and track the implementation and closure of action items related to quality of care data.

**2.** We recommended that supervisors implement appropriate actions for individuals assigned Level 2 or Level 3 peer reviews and that they notify the PRC upon completion of corrective actions.

**3.** We recommended that managers analyze and trend outcomes data related to the use of reversal agents in conjunction with moderate sedation procedures.

**4.** We recommended that processes be strengthened to ensure that providers perform and document reviews of patients' organ systems, current medications, and current allergies prior to procedures requiring moderate sedation and that compliance be monitored.

## 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 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 area that needed improvement.

FPPE. VHA requires that FPPEs be completed for all physicians who have been newly hired.[4] We did not find completed FPPEs for any of the five newly hired physicians.

**Recommendation**

**5.** We recommended that FPPEs be completed for newly hired physicians.

## 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 medical, surgical, special care, and mental health units and two community living center units. We also inspected same day surgery; the ED; and the dental, oncology, and cardiology clinics. The facility maintained a

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

generally clean and safe environment. However, we identified the following condition that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule. We reviewed 15 employee training records and found that 5 employees did not have this training documented.

**Recommendation**

**6.** We recommended that employees with occupational exposure risk receive annual bloodborne pathogens training and that compliance be monitored.

## COC

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

We reviewed 20 patients' medical records for evidence of advance directive notification, advance directive 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 areas that needed improvement.

Information on Advance Directives. VHA requires facilities to provide additional information about advance directives or assistance in completing forms to patients, if requested.[5] Although the facility's policy designated staff to provide additional information, we found that three of four patients who requested additional information did not receive it.

Advance Care Planning/Advance Directives Policy. VHA requires that health care staff follow specific procedures for advance care planning/advance care directives.[6] Local policy had not been updated to be consistent with current VHA policy. As a result, health care staff did not follow VHA-required procedures. For example, in the 20 records we reviewed, we found no documentation regarding notification to patients of their right to accept or refuse medical treatment, to designate a Health Care Agent, or to document their treatment preferences. Additionally, 19 of 20 records lacked required progress note titles used to identify advance care planning discussions or to indicate that patients had

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

completed advance directives.

**Recommendations**

**7.** We recommended that processes be strengthened to ensure that patients who request additional information about advance directives receive that information.

**8.** We recommended that facility policy for management of advance care planning/advance directives be updated to be consistent with current VHA policy and that compliance with the updated policy be monitored.

## 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' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[7] We reviewed the medical records of 15 EN patients and found that some records did not contain adequate documentation of required information. For example, six records did not include sufficient documentation that staff checked gastric residuals, and four lacked documentation that staff appropriately positioned patients in preparation for EN feeding.

**Recommendation**

**9.** We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

# Review Activities Without Recommendations

## Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with a 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

[7] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

## 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 designated chemotherapy room, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

## 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 assessments and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that actions were taken when deficiencies were identified.

# 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 13–17, for the full text of the Directors' comments.) We will follow up on the planned actions for the recommendations until they are completed.

| Facility Profile[8] | | |
|---|---|---|
| **Type of Organization** | Medical center | |
| **Complexity Level** | 2 | |
| **VISN** | 1 | |
| **Community Based Outpatient Clinics** | Auburn, ME<br>Bangor, ME<br>Calais, ME<br>Caribou, ME<br>Portland, ME<br>Rumford, ME<br>Saco, ME | |
| **Veteran Population in Catchment Area** | 138,545 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial Residential Rehabilitation Treatment Program** | 63 | |
| • **Community Living Center/Nursing Home Care Unit** | 69 | |
| **Medical School Affiliation(s)** | Tufts University School of Medicine/Maine Medical Center<br>University of New England College of Osteopathic Medicine | |
| • **Number of Residents** | 3.0 | |
| | **FY 2011 (through December 2010)** | **Prior FY (2010)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $242.3 | $250.7 |
| • **Medical Care Expenditures** | $90.7 | $248 |
| **Total Medical Care Full-Time Employee Equivalents** | 1,250.41 | 1,224.39 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 26,169 | 39,398 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 3,945 | 15,760 |
| o **Community Living Center/Nursing Home Care Unit** | 5,636 | 22,432 |
| **Hospital Discharges** | 562 | 2,392 |
| **Total Average Daily Census (including all bed types)** | 104.3 | 104.8 |
| **Cumulative Occupancy Rate (in percent)** | 57.8 | 62.2 |
| **Outpatient Visits** | 92,970 | 363,303 |

[8] 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 provider performance improvement data is collected and analyzed as part of the reprivileging process. | Service line supervisors use a data collection report for Ongoing Professional Practice Evaluation criteria during the reprivileging process. | Y | N |
| 2. Ensure PSB minutes reflect all required elements and are forwarded to the Director for review and approval. | Minutes meet current requirements and are forwarded to the Director for review and approval. | Y | N |
| 3. Ensure that PRC minutes reflect the required elements of the peer review process and that minutes are distributed for review and approval. | PRC minutes reflect all the required elements of the required 2008 process and are distributed for review and approval by the members of the committee. | Y | N |
| 4. Ensure the PRC reviews mortalities that meet criteria and report peer review activity quarterly to the Medical Executive Committee. | The PRC reviews identify mortalities that meet the criteria for peer review, and the chair of the committee gives a quarterly report to the Clinical Executive Board. | Y | N |
| 5. Ensure clinical managers include the use of reversal agents when monitoring moderate sedation outcomes. | Moderate sedation data was not modified to include the use of reversal agents; thus, outcomes from the use of reversal agents during moderate sedation were not monitored. | N | Y (see page 3) |
| **Pharmacy Operations** | | | |
| 6. Ensure controlled substances inspectors validate the security of blank prescription pads stored in the pharmacies. | Security validation for blank prescription pads is part of the pharmacy inspection checklist and is monitored by the Controlled Substance Coordinator. | Y | N |

| Recommendations | Current Status of Corrective Actions Taken | In Compliance Y/N | Repeat Recommendation Y/N |
|---|---|---|---|
| **EOC** | | | |
| 7. Ensure nursing personnel monitor and record temperatures in medication and nutrition refrigerators daily. | Hard copy temperature logs are present throughout the facility and are maintained on a daily basis by unit nurses. | Y | N |
| **ED/Urgent Care Clinic** | | | |
| 8. Install locks on ED doors, and improve security in the triage area. | Appropriate locks were installed on ED doors, a duress alarm was installed for employees staffing the triage desk, and police now regularly patrol the ED/triage area. | Y | N |
| **COC** | | | |
| 9. Ensure discharge summaries are completed, discharge instructions are consistent with discharge summaries, and patients receive written discharge instructions. | An ED discharge instruction template was developed and is used along with other discharge templates to ensure that discharge instructions are consistent with summaries and that patients receive written discharge instructions. | Y | N |
| **Medication Management** | | | |
| 10. Document pain reassessments within appropriate timeframes, and take actions when medications are ineffective. | The Bar Code Medication Administration coordinator monitors pain effectiveness variances, and nurse managers monitor pain reassessments within appropriate timeframes and the effect of pain control interventions. | Y | N |
| 11. Ensure nurses scan all patient wristbands prior to medication administration, and monitor compliance. | The Bar Code Medication Administration coordinator monitors patient wristband scans and contacts nursing supervisors immediately with any variance. | Y | N |

# VHA Satisfaction Surveys

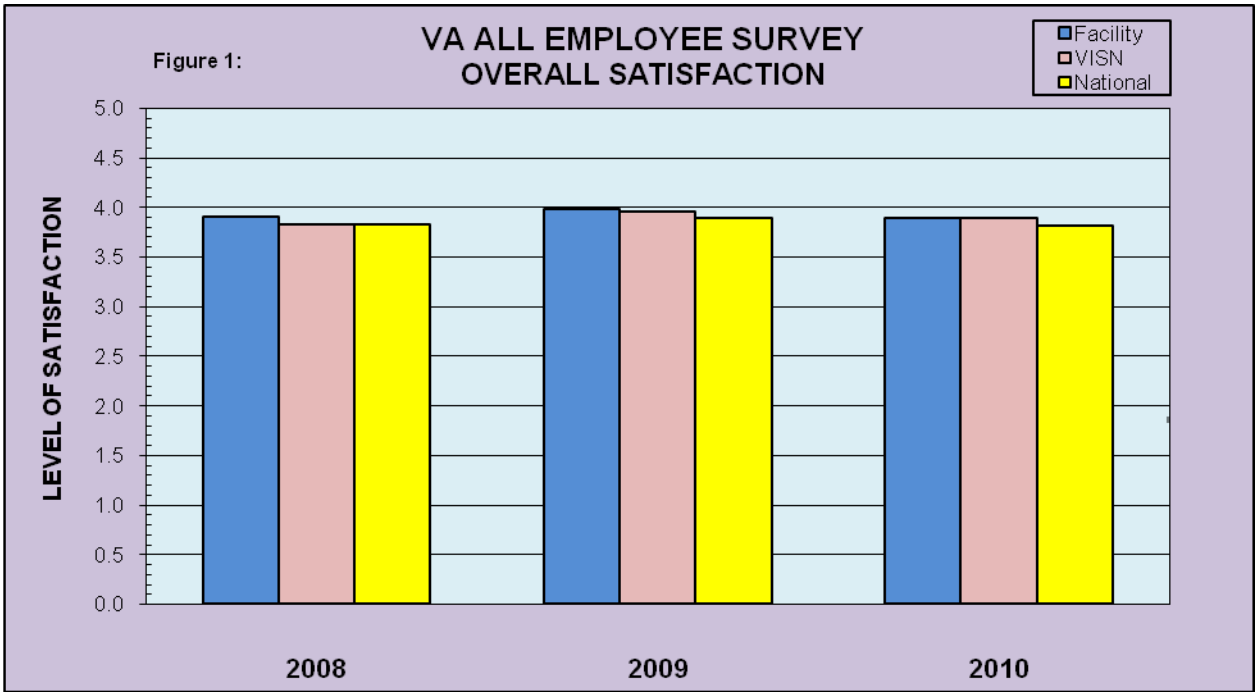
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

**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 | 67.4 | 62.3 | 72.2 | 62.0 | 56.3 | 67.1 | 67.7 | 59.4 |
| VISN | 69.3 | 69.6 | 64.1 | 63.1 | 61.0 | 61.1 | 62.7 | 61.6 |
| 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 | Congestive Heart Failure | Pneumonia | Heart Attack | Congestive Heart Failure | Pneumonia |
| Facility | * | 8.98 | 13.95 | * | 19.50 | 15.18 |
| VHA | 13.31 | 9.73 | 15.08 | 20.57 | 21.71 | 15.85 |

* Not enough cases.

[9] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, the 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 the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** July 13, 2011

**From:** Director, VA New England Healthcare System (10N1)

**Subj:** **CAP Review of the VA Maine Healthcare System, Augusta, ME**

**To:** Director, Bedford Office of Healthcare Inspections (54BN)

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

I have reviewed the findings and recommendations and concur. Our actions to the recommendations are attached.

Michael Mayo-Smith, MD, MPH
Network Director

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** July 12, 2011

**From:** Director, VA Maine Healthcare System (402/00)

**Subj:** **CAP Review of the VA Maine Healthcare System, Augusta, ME**

**To:** Director, VA New England Healthcare System (10N1)

1. We concur with the findings and recommendations presented in the VA Maine Healthcare System OIG Report. Comments to the report on the following pages comprise a brief implementation plan and target completion dates for each recommendation.

2. The organization benefited from the thorough review of the operations, systems, and processes, as well as from the inherent helpful, consultative nature of the team members' interaction with staff.

3. The goal to provide excellent quality of healthcare for the Veterans of Maine is, of course, always in our sights as we dedicate our efforts and resources every day.

4. Questions or further comments regarding this response can be directed to me with the anticipation of a complete and timely reply. Thank you.

BRIAN G. STILLER

# 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 all committees document and track the implementation and closure of action items related to quality of care data.

Target date for completion: September 11, 2011

Concur - All committee meeting minutes will use the Old Business/Open Item Matrix format that identifies the status of open or closed items. Open items will be tracked to completion and reported on up through Clinical Executive Board, Nurse Executive Board, Administrative Executive Board, and the Executive Committee of the Governing Body. Education concerning the matrix design and closing the loop will be completed for all committee chairs, nurse managers, and leadership staff.

**Recommendation 2.** We recommended that supervisors implement appropriate actions for individuals assigned Level 2 or Level 3 peer reviews and that they notify the PRC upon completion of corrective actions.

Target date for completion: Corrective action completed.

Concur - Performance improvement discussions with providers concerning identified systems issues will be reported back to the PRC. A tracking log has been modified to track all open actions to completion.

**Recommendation 3.** We recommended that managers analyze and trend outcomes data related to the use of reversal agents in conjunction with moderate sedation procedures.

Target date for completion: Corrective action completed.

Concur – A tracking tool implemented in October 2010 will continue to be used for tracking reversal agents in conjunction with moderate sedation. The data tool has been modified to include individual patient outcomes. A manager analyzes and trends data, sharing the information as regular item of the Invasive Procedure Committee.

**Recommendation 4.** We recommended that processes be strengthened to ensure that providers perform and document reviews of patients' organ systems, current medications, and current allergies prior to procedures requiring moderate sedation and that compliance be monitored.

Target date for completion: September 11, 2011

Concur – All staff who participate in the process of moderate sedation will be educated on using the modified templates, and the nurse manager will perform chart reviews to monitor compliance.

**Recommendation 5.** We recommended that FPPEs be completed for newly hired physicians.

Target date for completion: Corrective action completed.

Concur - Although FPPEs were initiated on the five newly hired physicians, the process was not stated in the PSB minutes or labeled and tracked in the provider profile as completed. The FPPEs are now titled as 'initial FPPE' and attached to the PSB minutes when completed.

**Recommendation 6.** We recommended that employees with occupational exposure risk receive annual bloodborne pathogens training and that compliance be monitored.

Target date for completion: September 11, 2011

Concur - All staff were reassigned Blood Borne Pathogen Training, and a weekly report is being run to track compliance, which is reported to service chiefs and senior leadership.

**Recommendation 7.** We recommended that processes be strengthened to ensure that patients who request additional information about advance directives receive that information.

Target date for completion: September 11, 2011

Concur – The Social Work Executive is drafting an informational brochure for patients' rights regarding information of Advance Directives. The staff will be educated on the process of providing Advance Directives information and documentation.

**Recommendation 8.** We recommended that facility policy for management of advance care planning/advance directives be updated to be consistent with current VHA policy and that compliance with the updated policy be monitored.

Target date for completion: September 11, 2011

Concur – The Social Work Executive has drafted a new policy, which includes all elements of Advance Directives as defined by VHA Directive. The Social Work Executive will review records quarterly to monitor compliance.

**Recommendation 9.** We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Target date for completion: September 11, 2011

Concur – Flow sheets for all areas of the facility that provide EN are being revised to include all required elements for EN as identified in VHA Directive. The medical support staff has been educated on scanning processes for the flow sheets and time requirements for scanning.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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