Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02086-28

Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, Iowa

November 17, 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.

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CPR	cardiopulmonary resuscitation
CS	controlled substances
EN	enteral nutrition
EOC	environment of care
facility	VA Central Iowa Health Care System
FY	fiscal year
MH	mental health
OIG	Office of Inspector General
PR	peer review
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Central Iowa Health Care System, Des Moines, IA

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 August 8, 2011.

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

- Enteral Nutrition Safety
- Medication Management

The facility's reported accomplishment was increased hiring of veterans and employees with disabilities.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure peer review extensions are requested in writing. Require reviews of current medications to be completed and documented in the required timeframe. Ensure results of medical record quality reviews are reported at least quarterly. Require employees to maintain current cardiopulmonary resuscitation certification.

Physician Credentialing and Privileging: Require that competency criteria be service-specific and that data be collected and reviewed during the reprivileging process. Ensure clinical privileges granted are appropriate to the provider's training and experience.

Registered Nurse Competencies: Ensure competency validation documentation is complete and legible. Complete the facility-wide nursing competency audit, and initiate corrective actions as needed.

Management of Workplace Violence: Update and strengthen the current workplace violence policy. Complete brief incident reports for all assaults involving patients. Discuss behavioral record flag placements with patients, and document the discussions.

Environment of Care: Complete annual N95 respirator fit testing, and monitor compliance. Secure all Veterans Canteen Service retail storage rooms.

Coordination of Care: Provide all components of written advance directive notification to patients, and document notification. Accurately document patient advance directive screening.

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.

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 August 8, 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 Central Iowa Health*

Care System, Des Moines, Iowa, Report No. 08-02597-63, February 3, 2009). (See Appendix B for further details.) The facility had repeat findings in QM and EOC from our previous review.

During this review, we also presented crime awareness briefings for 48 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

Increased Hiring of Veterans and Employees with Disabilities

In support of meeting employment goals, the facility's Human Resource Department concluded that a new way of recruiting applicants in targeted areas had to be developed and embraced. In April 2010, the facility hosted a collaborative learning session for community partners to develop the process and phase approach for recruitment. Phase I focused on recruiting specific high turnover positions through internal and direct hire authorities prior to external advertising. Phase II focused on recruitment of specialized or difficult to recruit positions.

The results were an increase in hiring of veteran employees by 2.9 percent and an increase in hiring of employees with disabilities by 0.63 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 policy requires facilities to complete a PR within 120 days.[1] Any extension beyond 120 days must be requested in writing from and approved by the facility's Director. Seven of the 13 PRs that exceeded 120 days did not have the required written request and approval for extension.

Moderate Sedation. VHA requires that providers document a review of current medications within 30 days prior to a procedure where moderate sedation will be used.[2] We reviewed the medical records of 10 patients who had selected procedures where moderate sedation was used. We found that seven of the records had incomplete or missing documentation of a review of current medications.

Medical Record Review. VHA requires that the results of medical records reviewed on an ongoing basis at the point of care be reported at least quarterly to the facility medical record review committee.[3] We found that the results of these record reviews were not reported to the Medical Records Committee.

CPR Certification. Facility policy requires identified staff to maintain current CPR certification. We reviewed the status of the 307 employees required to have CPR certification and found that 23 (7 percent) did not have current certification at the time of our inspection. This was a repeat finding from the previous CAP review.

Facility policy states that staff who do not maintain current CPR certification will be removed from direct patient care responsibilities. The facility was not in compliance with this policy at the time of our inspection. Twenty-two of the 23 employees with expired CPR certification were providing direct patient care.

Recommendations

1. We recommended that processes be strengthened to ensure that PR extensions are requested in writing from and approved by the facility's Director.

2. We recommended that processes be strengthened to ensure that reviews of current medications are completed

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

and documented in the required timeframe prior to procedures requiring moderate sedation.

3. We recommended that medical record review processes be strengthened to ensure that results of all medical record quality reviews are reported at least quarterly to the Medical Records Committee.

4. We recommended that processes be strengthened to ensure that employees maintain current CPR certification and that the action required by facility policy is taken when employees do not maintain certification.

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 areas that needed improvement.

Ongoing Professional Practice Evaluation. VHA requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing periodic basis.[4] The facility had implemented a policy that specified the performance data that would be collected, compiled, and considered during the reprivileging process.

We found that some criteria were not service-specific and that data collected did not meet the requirements of facility policy. For example, the percentage of discharge summaries completed within 24 hours was being measured for providers who did not admit or discharge patients. In addition, some facility required service-level data was not collected.

Clinical Privileges. VHA requires that providers possess the appropriate training and experience to justify requested clinical privileges.[5] For five physicians, we found that privileges were approved that were not appropriate for their training and experience. For example, one emergency department and four primary care providers were privileged

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

to provide MH services that they did not have the appropriate education or experience to provide.

Recommendations

5. We recommended that competency criteria be service-specific and that data be collected and reviewed during the reprivileging process in accordance with facility policy.

6. We recommended that processes be strengthened to ensure that clinical privileges granted are appropriate to the providers' training and experience.

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 and processes, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to perform their responsibilities. Core competencies, such as medication administration, are skills required for all RNs. Unit 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-specific competencies had been validated. All 12 folders had incomplete or illegible validation documentation.

During this review, management discovered that five competency assessments had been inappropriately signed. A facility-wide audit of nursing competencies has been initiated.

Recommendations

7. We recommended that processes be strengthened to ensure that competency validation documentation is complete and legible.

8. We recommended that management complete the facility-wide nursing competency audit and initiate corrective actions as needed based on the audit results.

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 policies and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following areas that needed improvement.

Facility Policy. The Occupational Safety and Health Administration require facilities to have a comprehensive written workplace violence policy. The facility's Workplace Violence Prevention Program policy was not current or comprehensive.

Management of Incident. The facility's Patient Safety Program policy requires all assaults involving patients to be reported electronically within 24 hours using the brief incident report system. We reviewed documentation of a patient-to-staff assault and did not find a brief incident report.

Patient Notification. When a patient's record is flagged for a behavioral problem, the Disruptive Behavior Committee charter requires that the patient's treatment team discuss the assault incident with the patient. We reviewed a medical record that had a behavioral patient record flag and did not find documentation that the treatment team discussed the action with the patient.

Recommendations

9. We recommended that the facility update and strengthen the current workplace violence policy to include detailed guidance for managing violent incidents involving patients, employees, and visitors.

10. We recommended that processes be strengthened to ensure that brief incident reports are completed for all assaults involving patients.

11. We recommended that processes be strengthened to ensure that when a patient's record is flagged for a behavioral problem, the treatment team discusses the assault incident with the patient and documents the discussion in the medical record.

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 and whether the

facility's domiciliary was in compliance with selected MH Residential Rehabilitation Treatment Program requirements.

We inspected selected inpatient (medical-surgical, acute MH, intensive care, community living center) units, the domiciliary, and the same day surgery and post-anesthesia care units. We also inspected the emergency department and the dental, primary care, and outpatient physical therapy clinics. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 23 employee records and determined that 12 designated employees did not have the required annual fit testing.

Security. Unsecured doors to Veterans Canteen Service retail storage rooms allow unauthorized access to food and merchandise. During our inspection, we found three out of the four storage rooms unlocked, and one of the doors was ajar. Only one storage room had an automatic lock installed. This was a repeat finding from the previous CAP review.

Recommendation

12. We recommended that annual N95 respirator fit testing be completed for all designated employees and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that Veterans Canteen Service retail storage rooms are secured at all times.

Coordination of Care

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 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.

Advance Directive 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 advance directive.[6] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an advance directive. We reviewed the medical records of 20 patients and found that 19 of the records did not contain evidence of all components of written notification.

Advance Directive Screening Accuracy. VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an advance directive and document the screening in the medical record.[7] Although advance directive screenings were completed for 19 of the 20 patients whose medical records we reviewed, 3 of the screenings were not accurate. Two screenings documented that there were no advance directives; however, we located advance directives for both patients in the electronic medical records. One screening documented that there was an advance directive; however, we did not locate an advance directive in the electronic medical record.

Recommendations

14. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

15. We recommended that processes be strengthened to ensure that patient advance directive screening is accurately documented in the medical record.

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' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

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

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 determined that the facility safely prepared, transported, and administered the medications. 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 17–23 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	General medical/surgical, acute psychiatry, long-term care, and domiciliary	
Complexity Level	2	
VISN	23	
Community Based Outpatient Clinics	Mason City, IA Marshalltown, IA Fort Dodge, IA Carroll, IA Knoxville, IA	
Veteran Population in Catchment Area	90,599	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	77 hospital 60 domiciliary	
• **Community Living Center/Nursing Home Care Unit**	140	
Medical School Affiliation(s)	University of Iowa College of Medicine Des Moines Area Medical Education Consortium, Inc. Des Moines University	
• **Number of Residents**	21	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$195.9	$187.6
• **Medical Care Expenditures**	$69.4	$187.6
Total Medical Care Full-Time Employee Equivalents	1,323	1,294
Workload:		
• **Number of Station Level Unique Patients**	25,727	31,834
• **Inpatient Days of Care:**		
o **Acute Care**	6,214	12,077
o **Community Living Center/Nursing Home Care Unit**	22,229	41,213
Hospital Discharges	1,171	2,379
Total Average Daily Census (including all bed types)	156	146
Cumulative Occupancy Rate (in percent)	44.3	43.0
Outpatient Visits	146,560	284,128

[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**
C&P			
1. Collect and consider provider-specific performance improvement data during reprivileging, in accordance with VHA policy.	Provider-specific performance improvement criteria is collected and considered during the reprivileging process in accordance with VHA policy.	Y	N
QM			
2. Require employees to complete CPR training in accordance with facility policy.	The CPR training database was updated to ensure alignment with policy and is monitored quarterly by Education Service. Additional CPR training opportunities were scheduled. Education Service monitors staff compliance with training and notifies supervisors/managers of delinquencies. Managers are to initiate corrective action when an employee's CPR training is delinquent.	N	Y (see pages 3–4)
3. Establish a committee to provide oversight and coordination of the medical record review process.	The facility chartered a Medical Records Committee, and the first committee meeting was held February 11, 2009. The committee has met regularly since its inception and is responsible for oversight and coordination of the medical record review process.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
4. Correct identified safety, infection control, and patient privacy deficiencies.	Identified safety, infection control, and patient privacy deficiencies were corrected.	N	Y (see page 7)
5. Require consultation responses to be completed within the facility's established timeframe.	Managers developed a consistent process to ensure that all inpatient consults are seen and that documentation is completed within established timeframes.	Y	N
6. Require transfer documentation to be completed in accordance with facility policy.	The nurse manager educated RNs regarding ensuring that they are the individuals signing inpatient transfers and not licensed practical nurses. Monthly record audits are performed to ensure compliance.	Y	N
7. Require discharge documentation to accurately reflect active outpatient medications.	Staff physicians were educated on facility policy to ensure patients' active medication lists are accurately reflected on discharge summaries. Monthly record audits are performed to ensure compliance.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Pharmacy Operations			
8. Require monthly inspections to be completed in all areas where CS are stored.	The CS Coordinator educated inspectors regarding the requirement for monthly inspections. In the event an inspector cannot complete the inspection, the CS Coordinator is contacted, and an alternate is assigned. CS inspection data shows one missed CS inspection in FY 2010 and FY 2011.	Y	N
Medication Management			
9. Require staff to follow facility policy regarding medication disposition upon admission.	A process for weekly random inspections to ensure medications are not stored on the unit has been implemented. The data reveals sustained improvement.	Y	N
10. Require the Self-Medication Management Program to be implemented and managed in accordance with facility policy.	The MH Service Line developed a handout to explain security requirements to patients and a template to document the required medication education. Practitioners write orders for the level of medication administration needed by a veteran on admission and as needed throughout treatment. Compliance is monitored, and data demonstrates sustained improvement.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
11. Require staff to document as needed medication effectiveness within the timeframe defined by facility policy.	A process for a daily audit of compliance documentation has been developed. Nurse managers provide timely feedback and assist individual staff with compliance.	Y	N
Emergency/Urgent Care Operations			
12. Require that patients discharged from the emergency department receive written discharge instructions.	The Emergency Department Discharge Patient Education Template was developed and implemented. Documentation shows compliance with VHA guidelines.	Y	N
13. Require that clinicians document inter-facility transfers in accordance with VHA policy.	Implementation and continued use of the VA Inter-facility transfer form and I-Med Consent form ensure the safe and appropriate transfer of emergency department patients. This is in accordance with VHA policy. Emergency department monitors were completed in March 2010, and data demonstrated 100 percent compliance.	Y	N

VHA Satisfaction Surveys

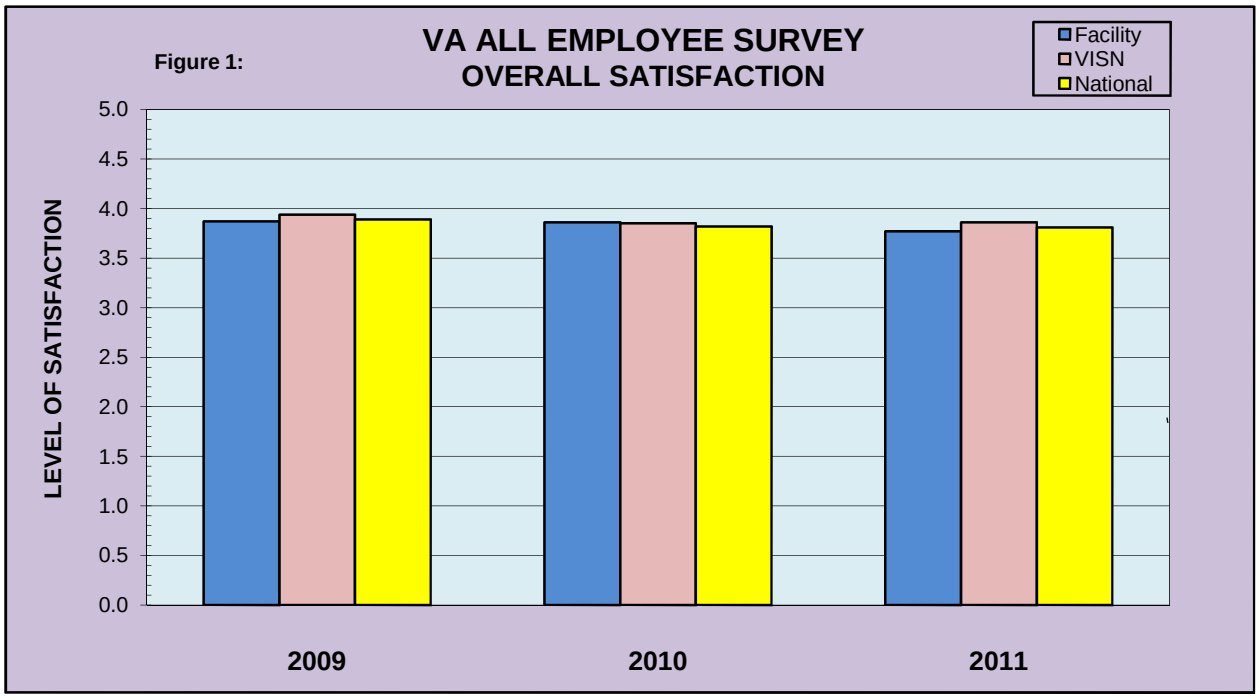
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	60.0	63.7	56.5	59.6	59.2	56.5
VISN	67.7	59.2	57.2	67.2	61.2	58.1
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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 2007–2010.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	13.34	9.00	11.31	*	16.79	12.44
VHA	12.54	9.24	12.02	12.99	19.66	15.15

* Not enough cases.

[9] 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: November 2, 2011

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the VA Central Iowa Health Care System, Des Moines, IA**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

I concur with the planned actions to be taken by VA Central Iowa Health Care System, Des Moines, IA, regarding the fifteen identified recommendations.

Janet P. Murphy

JANET P. MURPHY, MBA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 1, 2011

From: Director, VA Central Iowa Health Care System (636A6/00)

Subject: **CAP Review of the VA Central Iowa Health Care System, Des Moines, IA**

To: Janet P. Murphy, Director, VA Midwest Health Care Network (10N23)

See pages 19 through 23, below.

DC Cooper

DONALD C. COOPER

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 extensions are requested in writing from and approved by the facility's Director.

Concur.

Target date for completion: Completed 10/1/2011.

The PR Coordinator will review the PR database at least bi-weekly to ensure that written requests for extensions are initiated and subsequently approved by the facility Director within the 120 day timeframe.

Recommendation 2. We recommended that processes be strengthened to ensure that reviews of current medications are completed and documented in the required timeframe prior to procedures requiring moderate sedation.

Concur.

Target date for completion: 1/15/2012.

The process will be strengthened to ensure that the patient's current medication list will be documented in the electronic medical record within the required timeframe for procedures requiring moderate sedation. Service Line leaders will be responsible for developing a specific process to include development of appropriate note templates, and a plan for provider and nurse education. Compliance with the new process will be monitored monthly for the first three months and then quarterly to ensure sustained improvement.

Recommendation 3. We recommended that medical record review processes be strengthened to ensure that results of all medical record quality reviews are reported at least quarterly to the Medical Records Committee.

Concur.

Target date for completion: 2/1/2012.

The medical record quality reviews will be conducted and reported by each of the facility's Service Lines and reported to the Medical Records Committee on a quarterly basis. The Medical Records Committee will request corrective action plans as needed and monitor them monthly until the issues are resolved.

Recommendation 4. We recommended that processes be strengthened to ensure that employees maintain current CPR certification and that the action required by facility policy is taken when employees do not maintain certification.

Concur.

Target date for completion: 2/1/2012.

CPR certification of designated staff will be monitored on a regular and ongoing basis by the facility's Learning Service through an education tracking software program. If a staff member does not maintain current CPR certification, he/she will be removed from direct patient care responsibilities and may be subject to disciplinary action. A process to document and track removals from direct patient care will be established in collaboration with the Human Resources Service Line and the data on removals reported to facility leadership on a monthly basis.

All 23 staff identified by the OIG during the August 2011 CAP survey with expired certification at the time of survey are now recertified in CPR.

Recommendation 5. We recommended that competency criteria be service-specific and that data be collected and reviewed during the reprivileging process in accordance with facility policy.

Concur.

Target date for completion: 2/1/2012.

The Service Lines are revising their ongoing professional practice evaluation criteria to be provider and service-specific. Monitoring of data collection will be completed by the Service Chiefs and will be reported quarterly to the Executive Committee of the Medical Staff.

Recommendation 6. We recommended that processes be strengthened to ensure that clinical privileges granted are appropriate to the providers' training and experience.

Concur.

Target date for completion: 2/1/2012.

Service Chiefs are reviewing clinical privileges at the time of credentialing to ensure that each provider has the appropriate level of privileges and that the facility can support provision of the services identified.

Recommendation 7. We recommended that processes be strengthened to ensure that competency validation documentation is complete and legible.

Concur.

Target date for completion: 3/1/2012.

The facility will conduct a facility-wide audit of all nursing competencies for completeness and legibility. Thereafter, random audits will be conducted each month by the office of the Associate Director for Patient Care Services during calendar year 2012 and reported to facility leadership on a monthly basis. Leadership will initiate corrective actions as needed based on the audit results.

Recommendation 8. We recommended that management complete the facility-wide nursing competency audit and initiate corrective actions as needed based on the audit results.

Concur.

Target date for completion: 3/1/2012.

Management will initiate corrective actions as needed based on a facility-wide audit of all nursing competencies for completeness and legibility.

Recommendation 9. We recommended that the facility update and strengthen the current workplace violence policy to include detailed guidance for managing violent incidents involving patients, employees, and visitors.

Concur.

Target date for completion: 7/1/2012.

The workplace violence policy will be revised and strengthened to include detailed guidance for managing violent incidents involving patients, employees, and visitors.

Recommendation 10. We recommended that processes be strengthened to ensure that brief incident reports are completed for all assaults involving patients.

Concur.

Target date for completion: 7/1/2012.

The facility will assess and revise, as needed, the current process for ensuring completion of incident reports related to assaults. Staff will then be educated on the revised process prior to implementation.

Recommendation 11. We recommended that processes be strengthened to ensure that when a patient's record is flagged for a behavioral problem, the treatment team discusses the assault incident with the patient and documents the discussion in the medical record.

Concur.

Target date for completion: 7/1/2012.

The Mental Health Service Line and the Disruptive Behavior Committee will revise the process for discussing behavioral problems and assault incidents with the involved veteran, and documenting that discussion in the veteran's medical record.

Recommendation 12. We recommended that annual N95 respirator fit testing be completed for all designated employees and that compliance be monitored.

Concur.

Target date for completion: 1/1/2012.

Those identified employees needing N95 respirator fit testing are being scheduled for fit testing. To date, 84 percent of the identified employees have completed fit-testing. Integrated Safety Program staff will monitor the fit-testing program on a weekly basis to ensure that 100 percent compliance is achieved and maintained.

Recommendation 13. We recommended that processes be strengthened to ensure that Veterans Canteen Service retail storage rooms are secured at all times.

Concur.

Target date for completion: 10/31/2012.

All Veteran Canteen Service staff has received education and instruction regarding the requirement for retail storage rooms to be locked at all times when not actively in use. Veteran Canteen Service storage areas are currently located in a temporary location. At the temporary location all storeroom doors will have automatic door closures and will be locked and closed when stock is not actively being moved in or out of the area. Target date for completion is December 1, 2011. For Veterans Canteen Service permanent retail store location, all storerooms doors will have automatic door closures and key pads at each door.

Recommendation 14. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

Concur.

Target date for completion: 2/1/2012.

The required elements of the Advance Directive Notification will be embedded into the electronic Admission Nursing Assessment template as a forced-field that the nursing staff will be required to address with the veteran during completion and documentation of the mandatory Admission Nursing Assessment.

The nursing staff will be trained on the modified process and template by January 15, 2012 prior to implementation. Monitoring of the template to ensure that Advance Directive Notification is completed 100 percent of the time will be done monthly by the Nursing Record Review Team for six months following the date of implementation.

Recommendation 15. We recommended that processes be strengthened to ensure that patient advance directive screening is accurately documented in the medical record.

Concur.

Target date for completion: 3/1/2012.

The facility will revise the process for verification of the Advance Directive screening in the medical record. As part of the process, an audit team and schedule will be established to track and ensure compliance. Audit results will be shared with the Chief of Patient Care Services and the Social Work Executive for corrective actions as needed.

OIG Contact and Staff Acknowledgments

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