Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03081-54

Combined Assessment Program Review of the Erie VA Medical Center Erie, Pennsylvania

January 8, 2008

Washington, DC 20420

Why We Did This Review

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

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

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

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Table of Contents

	Page
Executive Summary	i
Introduction	1
Profile	1
Objectives and Scope	1
Results	3
Review Activities With Recommendations	3
Quality Management	3
Environment of Care	4
Review Activities Without Recommendations	8
Computerized Patient Record System Business Rules	8
Surgical Care Improvement Project	9
Survey of Healthcare Experiences of Patients	10
Appendixes	
A. VISN Director Comments	13
B. Medical Center Director Comments	14
C. OIG Contact and Staff Acknowledgments	18
D. Report Distribution	19

Executive Summary

Introduction

During the week of October 15–19, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Erie VA Medical Center (the medical center), Erie, PA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 153 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered five operational activities. We made recommendations in two of the activities reviewed. For these activities, the medical center needed to:

- Improve QM processes in peer review and root cause analysis (RCA).
- Ensure that administrative rounds teams include appropriate disciplines and that all community based outpatient clinics (CBOCs) are included in the scheduled semi-annual rounds.
- Implement the standard operating procedures (SOPs) for the bulk oxygen utility system.
- Secure dirty utility room doors to prevent unauthorized access.
- Conduct initial and annual fit-testing for employees participating in the Respiratory Protection Program.
- Develop a policy to ensure that the Emergency Department (ED) is staffed with clinicians certified in Advanced Cardiac Life Support (ACLS).
- Secure protected patient health information.

The medical center complied with selected standards in the following three activities:

- Computerized Patient Record System Business Rules.
- Surgical Care Improvement Project.
- Survey of Health Experiences of Patients (SHEP).

This report was prepared under the direction of Randall Snow, J.D., Associate Director, Washington, D.C., Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is a tertiary care facility located in Erie, PA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs in Meadville, Smethport, Warren, and Oil City, PA, and in Ashtabula, OH. The medical center is part of VISN 4 and serves a veteran population of about 73,500 throughout Ashtabula County, OH; Chautauqua County, NY; and Crawford, Erie, Elk, Forest, McKean, Venango, and Warren counties in Pennsylvania.

Programs. The medical center is a teaching hospital and provides a full range of primary care, specialty care, and long-term care services in medicine, surgery, behavioral health, physical medicine, rehabilitation, dentistry, and geriatrics. It has 26 hospital beds and 39 nursing home beds.

Affiliations. The medical center is affiliated with Lake Erie College of Osteopathic Medicine (LECOM) and with LECOM's School of Pharmacy and provides training for approximately 300 residents. It has nursing program affiliations with Gannon University, Edinboro University, Graceland College, Mercyhurst College, Clarion University, and Slippery Rock University.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled more than $62 million. The FY 2007 medical care budget was approximately $72 million. FY 2006 staffing was 465.7 full-time employee equivalents (FTE), including 26.8 physician and 106.5 nursing FTE.

Workload. In FY 2006, the medical center treated 20,024 unique patients and provided 5,620 inpatient days in the hospital and 13,216 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 5,400 discharges, and the average daily census, including nursing home patients, was 50.4. Outpatient workload totaled 220,935 visits.

Objectives and Scope

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

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

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

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following five activities:

- Computerized Patient Record System Business Rules.
- Environment of Care (EOC).
- QM.
- SHEP.
- Surgical Care Improvement Project.

The review covered medical center operations for FY 2006, FY 2007, and FY 2008 through October 18, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Erie, Pennsylvania,* Report No. 04-01619-211, September 24, 2004). The medical center had corrected all health care related conditions identified during our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 153 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Director, Chief of Staff, Chief Nurse Executive, and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care in the medical center. However, we identified the following areas that needed improvement.

Peer Review. The peer review process did not include all components required by Veterans Health Administration (VHA) Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate the quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care[1] with subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings. Initial peer reviews must be completed within 45 days from the date of determination that a peer review is necessary. Of the 22 peer reviews initiated since September 2006, 18 were completed within this timeframe. Final evaluations by the PRC should be completed within 120 days from the date of determination that a peer review is necessary. Six of the 22 peer reviews we evaluated were not completed within the 120 days due to the inability to form a quorum at PRC meetings.

[1] Peer review levels: Level 1– Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

Root Cause Analysis. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires completion of an RCA within 45 days of identification of a sentinel event.[2] We reviewed eight individual RCAs; four of the eight were completed within 45 days. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could not be assured of a comprehensive and efficient patient safety process.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director improves the peer review process by completing initial peer reviews within the 45-day standard and final peer reviews within the 120-day standard.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director improves processing times for RCAs.

The VISN and Medical Center Directors agreed with the findings and recommendations. Senior management will increase the number of members on the PRC and monitor timeliness of peer reviews. RCA teams will be required to brief executive leadership within the 45-day time limit. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine whether the facility had established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration (OSHA), and Joint Commission standards.[3] To evaluate EOC, we inspected selected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. Overall, we found the facility to be clean and well maintained. Interim Life Safety Measures were implemented and monitored at all construction sites. The following conditions required management attention.

Administrative Rounds. Administrative rounds by the medical center inspection team allow management-level staff to identify and correct sanitation discrepancies, unsafe

[2] A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

[3] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

working conditions, and OSHA regulatory violations. The medical center program provides for semi-annual inspections of the medical center, the Veterans Outreach Center, and the CBOCs. Local policy designates the following individuals to conduct rounds at the medical center:

- Safety and Occupational Health Manager.
- Emergency Preparedness Coordinator.
- Infection Control Practitioner.
- Information Security Officer.
- Privacy Officer.
- Executive Leadership Team representative.
- Associate Director of Facilities Management.

Rounds must be attended by each member of the seven-member inspection team or a designated alternate. For FY 2007, none of the rounds were conducted by a full seven-member team. The medical center has five CBOCs. Rounds were conducted in four of the CBOCs but without full team participation. Additionally, the McKean CBOC, a VA contract facility, was not included in the CBOC rounds schedule.

Bulk Oxygen. The medical center's Annual Workplace Evaluation (AWE), conducted in January 2007, found that the written SOPs for the bulk oxygen utility system were not specific enough and that the alarm set points were not identified in the vendor's annual test report. Technical aspects of the SOPs were identified as deficient. For example, the SOPs failed to indicate the volume of oxygen supply available when the low alarm is triggered or the minimum amount of oxygen line pressure required before switching to the backup system. The projected abatement date was March 31, 2007. At the time our visit, the revised SOPs were not completed and had not been submitted to the EOC Committee for implementation.

Dirty Utility Rooms. According to Joint Commission and OSHA standards, dirty utility rooms must be locked to prevent mishandling of hazardous materials and waste. We found that the rooms had hazardous waste posters displayed on the doors stating that only authorized personnel could enter, but the doors had no locks. The medical center's January 2007 AWE found that doors to the dirty utility rooms

and infectious waste storage rooms were unlocked, allowing unrestricted access. The medical center's risk assessment determined that it was safe to leave the doors unlocked and recommended continued monitoring for any incidents. In our review, we found evidence that this practice may be unsafe. For example, the Intensive Care Unit (ICU) dirty utility room is in a hallway out of sight of staff. Other dirty utility rooms present similar risks of unauthorized access to rooms where hazardous waste is stored.

Respirator Fit-Testing. Annual fit-testing for employees was not completed in accordance with OSHA and VA standards.[4] The medical center is required to identify and designate a minimum number of staff to support current infectious disease programs based on local needs and a clear strategy. Individuals identified to wear a respirator must undergo initial and annual fit-testing. The medical center is performing initial fit-testing only.

Emergency Department. The ED staffing model used for the night shift (12:00 a.m. to 8:00 a.m.) did not include a dedicated registered nurse (RN) with ACLS certification. The ED staffing for this shift included a medical administrative assistant (MAA), who is the first point of contact for the incoming ED patient but is not trained in Basic Life Support; the Admitting Officer of the Day (AOD), who is a physician; and an on-call patient care facilitator (PCF), who is an RN. Both the AOD and the PCF have collateral responsibility for medical coverage elsewhere in the medical center, which includes the medical wards and the ICU. When the AOD is called out of the ED, the MAA notifies the PCF. The PCF determines if an RN certified in ACLS or if the PCF herself needs to staff the ED until the AOD returns. Currently, the medical center's night shift includes four RNs with ACLS certification, two on the ICU and two on medical-surgical wards. The medical center recognized the need for adding a full-time RN position to the ED night shift and has advertised to fill the position.

The medical center has insufficient staffing on the night shift, and the current staffing model creates a patient safety risk. Under the current staffing model, the ED, which is open 24 hours a day, cannot comply with VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility*

[4] OSHA Standard 1910.134, *Respiratory Protection*, and VHA Health Information Letter 10-2005-023, *Respiratory Protection Used for Infectious Disease and Annual Fit-Testing*.

Emergency Departments, and provide veterans with access to emergency care that is prompt, safe, appropriate, and cost effective.

We reviewed 6 months of ED census data, the Memorandum of Understanding (MOU) with the emergency care ambulance service, and the medical center's transfer and diversion policies. We determined that there is no written MOU with local community hospitals for diversion or transfer, but historically, local hospitals have always accepted VA patients for transfer.

Protected Health Information. Patient health information is required to be protected from unauthorized disclosure, as mandated by the Health Insurance Portability and Accountability Act of 1996. On the long-term care units, medical records that contained patients' names and full social security numbers were stored in the center alcoves and at the east/west working stations—areas of open, public access. Also on these units, patient schedules with protected health information were left unsecured on counters, and computer terminals with visible patient information were unattended.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the bulk oxygen utility system SOPs be completed, approved, and published and that the SOPs include a narrative of system operations.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that dirty utility rooms are locked.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires initial and annual respirator fit-testing for employees who participate in the Respiratory Protection Program.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires revision of the night shift ED staffing model to include a full-time RN, development of

an interim policy delineating the process for ED coverage by ACLS certified providers, and training in Basic Life Support and behavioral health for the MAA.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that patients' protected health information is secured.

The VISN and Medical Center Directors agreed with the findings and recommendations. Local policies have been revised to ensure full membership on EOC teams, and the contracted CBOC was inspected. A memorandum for the bulk oxygen utility system has been drafted and is being routed for approval. Key punch locks have been ordered for dirty utility rooms. Additional respiratory fit-testing kits have been ordered to facilitate annual testing. An RN was hired to staff the ED. Locks have been placed on the medical record storage compartments. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Computerized Patient Record System Business Rules

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the time and date recorded.

A communication (software informational patch[5] USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical records system.[6] The OI cautioned that, "the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006,

[5] A patch is a piece of code added to computer software in order to fix a problem.

[6] VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center's Privacy Officer.

The medical center requires all business rules to be approved through the Medical Records Committee prior to use, and any changes in business rules are reported to the Medical Executive Council (MEC). Additional procedures are used to review requests for retracting notes (for example, notes entered on the wrong patient). Prior to review by the Privacy Officer, the requesting provider must make an addendum to the medical record and submit the request for retraction to the responsible service chief for concurrence.

We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. We found that all of the business rules provided to the OIG inspector were in compliance with VHA Handbook 1907.1. We made no recommendations.

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 13 patients who had surgery performed during the 3rd quarter of FY 2007. The review included medical records for colorectal and orthopedic (knee or hip replacement) surgeries.

We evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first

surgical incision. The time of administration depends on the antibiotics given.

- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the scores summarized in the table below.

Performance Measure	Performance Measure Score
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled body temperature – colorectal surgery	70 percent

Our review showed that the medical center appropriately administered and discontinued antibiotics or documented clinical reasons why this did not occur. Clinicians monitored and controlled immediate post-operative body temperature for patients who had colorectal surgery performed. Results are displayed in the table below.

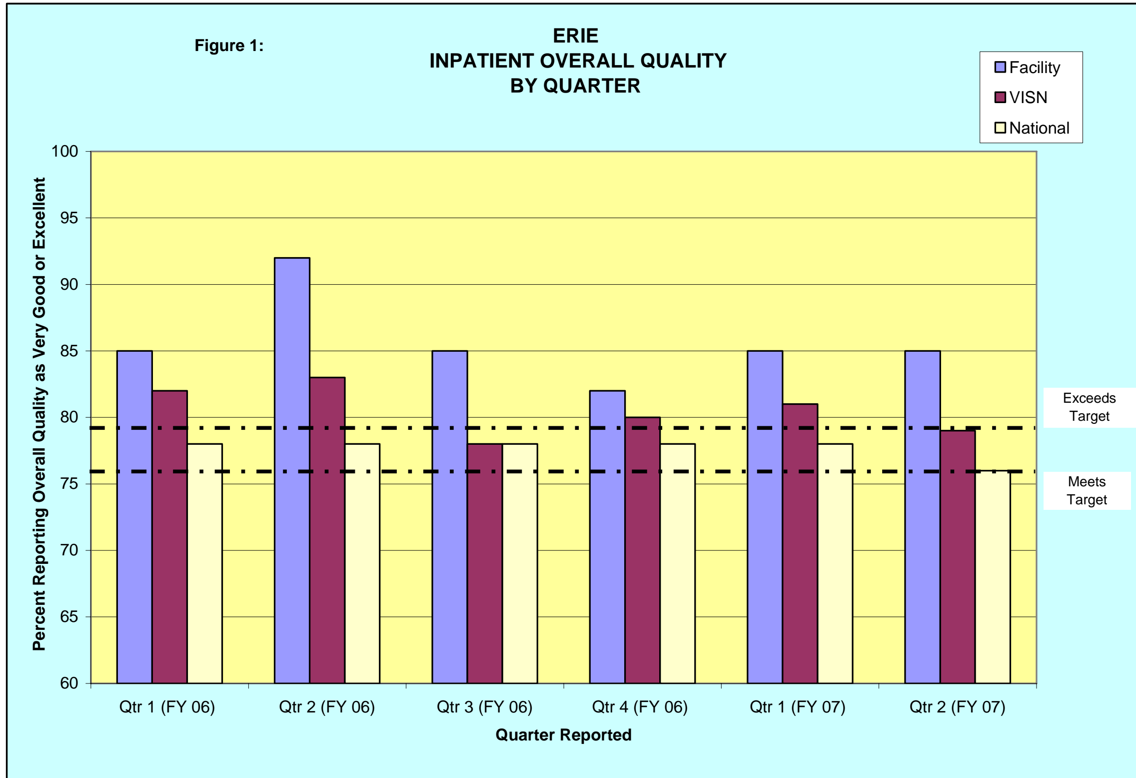
Antibiotic given timely	Antibiotic stopped timely	Body temperature control (colorectal surgery)
100 percent (13/13)	100 percent (13/13)	100 percent (5/5)

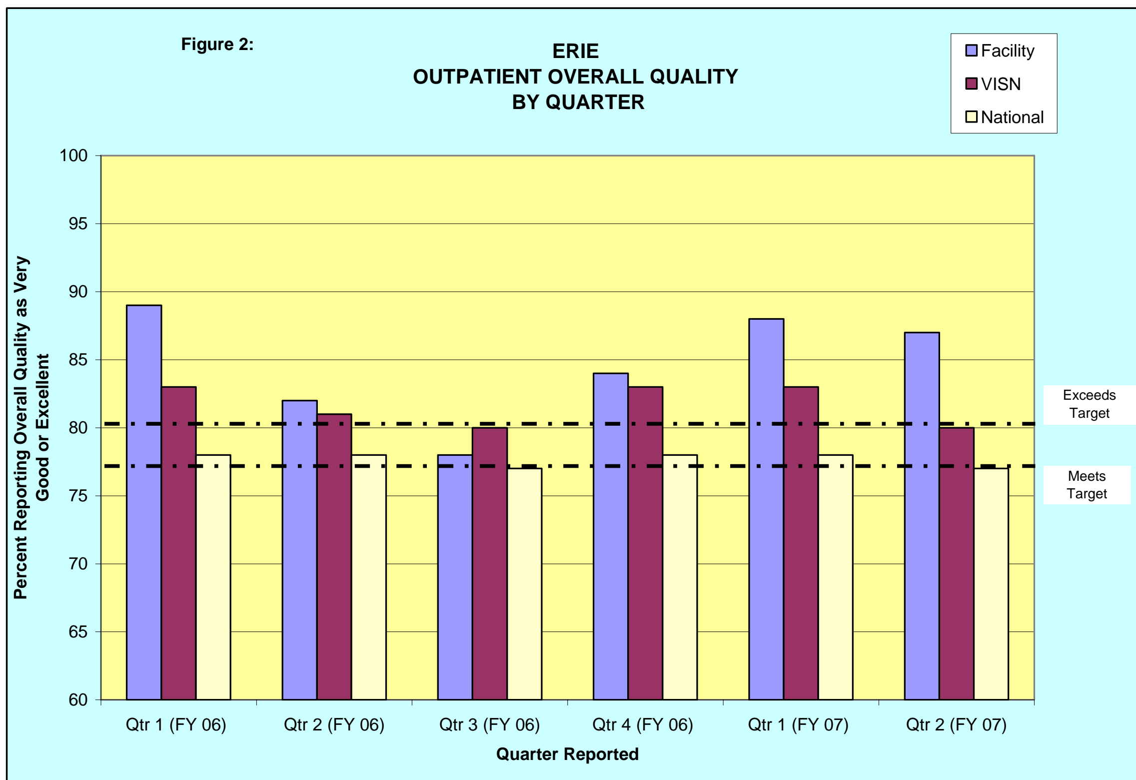
We made no recommendations.

Survey of Health Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set PM results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figures 1 and 2 below show the medical center's SHEP PM results for inpatients and outpatients.





The medical center has exceeded the established target for inpatient scores for the last 6 quarters of available data and met or exceeded the established target for outpatient scores for the last 6 quarters of available data. There is evidence of management involvement in improving patient satisfaction on all levels at the medical center and at the VISN level.

A multidisciplinary Customer Service Committee (CSC) meets monthly to review SHEP results and look for outliers, which they correlate with internal issues or problems. Action plans and initiatives are made on the service line level and tracked by the committee. The CSC reports to the Executive Leadership Board and the MEC quarterly and provides survey scores to Veterans Service Organizations. Other activities include a committee that evaluates all patient correspondence for reading and comprehension appropriateness, a quarterly information letter titled "Salute Your Health" for veterans, and a quarterly newsletter to the medical staff that reports patient satisfaction results. Patient education calendars are distributed annually, and there is a new initiative to call all discharged patients to assess satisfaction with their care while hospitalized.

We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 20, 2007

From: VISN Director

Subject: **Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania**

To: Associate Director, Washington, D.C., Region Healthcare Inspections Division (54DC)

Director, Management Review Office (10B5)

I concur with the recommendations and actions planned by the VA Medical Center. We thank you for the opportunity to improve care for our nation's veterans.

(original signed by:)

MICHAEL E. MORELAND, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 19, 2007

From: Director, Erie VA Medical Center

Subject: **Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania**

To: **Associate Director, Washington, D.C., Regional Office of Healthcare Inspections**

1. I have reviewed the draft report of the Inspector General Combined Assessment Program (CAP) of the Erie VA Medical Center. I concur with the findings and recommendations outlined in this report.

2. We would like to request a change to the facility profile under workload, the average daily census, including nursing home patients, was 50.4.

3. If additional assistance is needed, please contact Beth Sahlmann, Performance & Quality Officer (814) 860-2226.

(original signed by:)

MICHAEL D. ADELMAN, MD

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director improve the peer review process by completing initial peer reviews within the 45-day standard and final peer reviews within the 120-day standard

Concur

Response: We have consistently met the 45-day standard for completion of the initial peer review. In order to improve our completion of the final peer review within 120 days, we are in the process of recruiting additional members for the Peer Review Committee (PRC). Adding to the membership will improve scheduling and attendance at the PRC meetings. Timeliness of peer review completion will be shared with leadership monthly. **Action to be completed by January 31, 2008.**

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director improve processing times for Root Cause Analyses.

Concur

Response: When an RCA team is chartered, we have scheduled the executive briefing for each RCA within the 45-day timeframe to keep the RCA teams on track. We have also changed the process to allow the Acting Director to sign off on the RCA report. We are also piloting an all day RCA session to dedicate team members to the RCA process. The last three RCAs have been completed and signed off within the 45-day timeframe. **Action completed on November 16, 2007.**

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

Concur

Response: The Administrative Rounds Medical Center Memorandum (MCM) has been revised to reflect current membership per the

March 5, 2007, DUSHOM memorandum. The contracted CBOC was added to the Administrative Rounds schedule and was inspected on October 26, 2007. The revised MCM is being routed for approval, and the form for attendance will be revised. **Action to be completed by January 31, 2008.**

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the bulk oxygen utility system SOPs be completed, approved, and published and that the SOPs include a narrative of system operations.

Concur

Response: A medical center memorandum (MCM) has been drafted and is being routed for approval. Staff education will be completed following approval. **Action to be completed by March 31, 2008.**

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that Dirty Utility Rooms are locked.

Concur

Response: Key punch locks with proximity readers have been ordered for all of the dirty utility rooms. The locks will be installed as soon as they arrive on station. **Action to be completed by February 29, 2008.**

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires initial and annual Respirator Fit-Testing for employees who participate in the Respiratory Protection Program.

Concur

Response: Initial fit-testing has always been performed during New Employee Orientation. Additional fit-testing kits have been ordered. Staff requiring annual fit-testing will be scheduled and completed. A long-term plan is in place to perform ongoing annual fit-testing and training during our quarterly competency fairs. **Action to be completed by February 29, 2008.**

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires revision of the night shift ED staffing model to include a full-time RN, development of an interim policy delineating the process for ED coverage by ACLS certified providers, and Basic Life Support and behavioral health training for the MAA.

Concur

Response: One FTEE RN has been hired to staff the Emergency Room on night shift starting in December. An additional 0.6 FTEE RN was approved for night shift, and recruitment has begun. The interim procedure for ED coverage by ACLS certified providers was communicated to staff. All MAA staff has received a full day of training regarding Disruptive Behavior. **Action to be completed by January 31, 2008.**

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that patients' protected health information is secured.

Concur

Response: The medical record storage compartments will have standardized locks installed, and keys will be distributed to all nursing staff that require access. Nursing supervisors will monitor compliance to ensure that chart storage areas are locked when the satellite nurses stations are unattended. **Action to be completed by December 31, 2007.**

OIG Contact and Staff Acknowledgments

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