Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00786-116

Combined Assessment Program Review of the VA Palo Alto Health Care System Palo Alto, California

April 23, 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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Executive Summary

Introduction

During the week of March 3–6, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Palo Alto Health Care System (VAPAHCS), Palo Alto, CA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 1,152 employees. The VAPAHCS is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strengths and reported accomplishments:

- Highest aggregate scores for quality.
- Emergency department (ED) electronic tracking system.
- Registered nurse (RN) residency program.
- Post-operative pneumonia prevention program.

We made recommendations in three of the activities reviewed. For these activities, the VAPAHCS needed to:

- Review all physicians' privileges to ensure that they are appropriate and implement a mechanism to ensure that changes in physicians' work assignments at any time are accompanied by commensurate privilege changes.
- Initiate a mechanism to discuss all cases where review processes might identify adverse events so that the cases can be considered for disclosure and require documentation of full disclosure, as appropriate.
- Develop a plan for continuous performance review, including provider-specific QM/performance improvement (PI) results, and maintain provider profiles that demonstrate that the plans are being followed.
- Require that the weekly controlled substances (CS) inventory checks be performed in all appropriate areas.
- Appoint an adequate number of CS program inspectors to perform all required inspections.
- Ensure that reappointments of CS inspectors comply with Veterans Health Administration (VHA) policy.

- Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframe.

The VAPAHCS complied with selected standards in the following activities:

- ED Operations.
- Environment of Care (EOC).
- Patient Satisfaction Survey Scores.
- Staffing.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles Office of Healthcare Inspections.

Comments

The VISN and VAPAHCS Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 14–18, 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 VAPAHCS is a multi-division, tertiary facility located in Palo Alto, CA, that provides a broad range of inpatient and outpatient health care services. It operates three inpatient divisions in Palo Alto, Menlo Park, and Livermore, CA. Additional outpatient care is provided at six community based outpatient clinics in San Jose, Seaside, Capitola, French Camp, Modesto, and Sonora, CA. The VAPAHCS is part of VISN 21 and serves a veteran population of nearly 300,000 throughout a 10-county catchment area.

Programs. The VAPAHCS provides medical, surgical, behavioral, geriatric, spinal cord injury/disorders, and rehabilitation (blind and traumatic brain injury) services. It has 277 hospital, 100 domiciliary, 96 Psychosocial Residential Rehabilitation Treatment Program, and 424 nursing home beds.

Affiliations and Research. The VAPAHCS's primary academic affiliation is with Stanford University's School of Medicine. Training is provided for 1,541 individuals, including medical students, interns, residents, and fellows, from 182 academic institutions and for health trainees in various disciplines.

The VAPAHCS operates one of the largest research enterprises in VHA and has an annual research budget of more than $52 million. Important areas of research include spinal cord regeneration, traumatic brain injury, Alzheimer's disease, and bone and joint rehabilitation. The VAPAHCS was selected as the site for the first VA Center for Quality Management in HIV[1] Care and is home to a patient safety inquiry center, which operates two state-of-the-art simulation centers.

Resources. The fiscal year (FY) 2008 medical care operating budget is $624 million. FY 2007 staffing was 3,080 full-time employee equivalents (FTE), including 236 physician and 634 nursing FTE.

Workload. In FY 2007, the VAPAHCS treated 56,654 unique patients. The inpatient care workload totaled 8,435 discharges, and the average daily census, including

[1] HIV is the acronym for human immunodeficiency virus.

nursing home patients, was 653. Outpatient workload totaled 582,119 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 seven activities:

- ED Operations.
- EOC.
- Medication Management.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations and CS Inspections.
- QM.
- Staffing.

The review covered VAPAHCS operations for FY 2007 and FY 2008 through March 3, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the VAPAHCS (*Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California,* Report

No. 04-03359-105, March 16, 2005). The VAPAHCS had addressed all findings related to health care from our prior CAP review.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Final Report: Quality of Care Review, Polytrauma Rehabilitation Center, Palo Alto Health Care System, Palo Alto, CA,* August 9, 2007). In that report, the OMI made recommendations to strengthen leadership, ensure appropriate privileges, foster team building, develop a family program, reorganize case folders, and review two cases. We reviewed the actions taken by the VAPAHCS to address the recommendations and found them to be acceptable. We consider the OMI recommendations closed.

During this review, we presented fraud and integrity awareness briefings for 1,152 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. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Highest Aggregate Scores for Quality

The VAPAHCS has achieved the highest aggregate scores for quality among the most complex VA facilities in category 1a[2] for 2 consecutive years (FYs 2006 and 2007). In FY 2007, the VAPAHCS's aggregate performance measure score for access, clinical care, and satisfaction was 86.3 percent. The average national score for category 1a facilities was 81.4 percent, and the range was 74.6–86.3 percent. Managers credited strong leadership support, an aggressive clinical practice guideline program, and continuous performance monitoring as the key elements for this achievement.

[2] Level 1a facilities are those with the most complex ICU units; largest levels of volume, patient risk, teaching, and research; and the largest number and breadth of physician specialists. There are 30 VA facilities in this category.

Emergency Department Electronic Tracking System

The VAPAHCS's ED incorporated an electronic patient tracking system to facilitate and monitor patient flow through the department and to provide customized, high quality, and patient-friendly discharge instructions. Data collected from this system have been pivotal in determining physician and nurse staffing levels and in reporting performance monitors and patient flow information. A similar electronic patient tracking system is being developed by VHA for future use in all VA EDs.

Registered Nurse Residency Program

To be more competitive in recruiting new RN graduates and to reduce turnover, the VAPAHCS was the first VA facility to implement the Versant[3] 18-week RN residency program. In 2007, two groups of new graduates (33 total RNs) completed the program. Non-VA facilities that have adopted this program have seen dramatic reductions in new RN graduate turnover rates (less than 10 percent). The VAPAHCS anticipates a savings of more than $1 million in RN replacement costs if they successfully retain these nurses for 2 years from hire. An additional benefit is the positive image of the VA as "employer of choice" among the younger nurses because of their positive experiences in the program.

Post-Operative Pneumonia Prevention Program

VAPAHCS clinicians implemented a post-operative pneumonia prevention program when 2006 data revealed that the facility's pneumonia rate (1.7 percent) was slightly above the national rate (1.5 percent). Managers deployed an interdisciplinary team to implement evidence-based nursing interventions, such as providing more frequent oral hygiene, raising the head of the bed, and assisting with ambulation, to reduce post-operative pneumonia. By the end of 2007, the VAPAHCS's pneumonia rate (1.2 percent) was below the national rate (1.3 percent).

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the VAPAHCS's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the VAPAHCS Director, Chief of Staff, and Chief of QM. We also

[3] Versant is a private, non-profit education consulting group.

interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the VAPAHCS's quality of care. Appropriate review structures were in place for 12 of the 15 program activities reviewed. However, we identified three areas that needed improvement.

Physician Privileges. We identified problems in the areas of surgery and moderate sedation that needed immediate action. One surgeon had been given full surgical privileges even though there was no evidence that he had performed any surgeries in the past 2 years. Three active ED physicians' privileges did not include moderate sedation, and one of these three provider's privileges was signed off by only the Chief of Extended Care (EC) Service (not the Chief of the ED). For one of the ED physicians, a database (VISNPro) reflected current moderate sedation privileges. The privileging issues for the surgeon and two of the three ED physicians were corrected while we were onsite. The remaining ED physician was not scheduled to work until after the next regularly scheduled committee meeting. Because these problems were found on random physician selections, VAPAHCS managers need to conduct a more thorough review to determine whether these issues are more widespread.

Recommendation 1 We recommended that the VISN Director ensure that the VAPAHCS Director requires that the Medical Staff Coordinator, in conjunction with all clinical service chiefs, review all physicians' privileges to ensure that current privileges match current work, privileges are signed off by the appropriate chief(s), all reference sources (documents, paperwork, computer programs) reflect correct privileges, and changes in work assignments at any time are accompanied by commensurate privilege changes.

The VISN and VAPAHCS Directors concurred with the findings and recommendation. All applicable physician credentialing and privileging folders will be reviewed. The Medical Staff Office (MSO), in conjunction with service chiefs, will ensure that current privileges match current work. The target date for completion is September 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Adverse Event Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy requires that staff discuss the events with the patients and, with input from VA Regional Counsel, inform them of their right to file tort or benefits claims. During the period January 2007–January 2008, the VAPAHCS disclosed nine cases. However, we identified at least six cases of adverse events that had not been considered for disclosure. VAPAHCS managers need to determine a mechanism to discuss all cases where review processes might identify adverse events so that the cases can be considered for disclosure.

Recommendation 2 We recommended that the VISN Director ensure that the VAPAHCS Director requires that appropriate managers develop a mechanism to discuss all cases where review processes might identify adverse events so cases can be considered for disclosure and that full disclosure is documented, as appropriate.

The VISN and VAPAHCS Directors concurred with the finding and recommendation. The electronic adverse event disclosure template has been revised to capture both clinical and institutional disclosures. All practitioners will be required to document unanticipated events using the new template. The Risk Manager will review all disclosures and discuss events with senior management to determine whether an institutional or large scale disclosure is warranted. The target date for completion is May 31, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Provider Profiles. As of January 1, 2007, accreditation standards require that clinical managers continuously review performance, including QM and PI data and results, for all privileged providers. We did not find any evidence that clinical service chiefs had developed plans that define the provider-specific QM/PI results that will be reviewed or the frequency of review.

Recommendation 3 We recommended that the VISN Director ensure that the VAPAHCS Director requires clinical service chiefs to develop plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that demonstrate that the plans are being followed.

The VISN and VAPAHCS Directors concurred with the findings and recommendation. All clinical services will be required to develop plans for continuous performance review, which will be monitored quarterly by the MSO for each provider. The target date for completion is July 31, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations and Controlled Substances Inspections

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure the pharmacy's security and proper management of CS. We also determined whether processes were in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

The pharmacy's internal environment was clean and well maintained. The clean room, where sterile intravenous medications were manufactured, complied with VHA regulations and infection control (IC) standards.

The VAPAHCS had appropriate procedures to ensure that clinical pharmacists identified patients who were receiving multiple prescription medications, reviewed their medication regimens to avoid polypharmacy, and appropriately advised providers. Also, monthly unannounced inspections of all areas where CS were stored or dispensed were conducted as scheduled. However, we found several areas that needed management attention.

Weekly Inventories. We found that weekly inventories of automated dispensing units on inpatient wards had not been performed, as required by VHA policy. The inspection checklist and the local policy did not include this requirement. As a result, automated unit inventories had not been verified during monthly inspections.

Recommendation 4 We recommended that the VISN Director ensure that the VAPAHCS Director requires that weekly inventory checks be performed in all appropriate areas and that the checklist and the local policy be updated to reflect this requirement.

The VISN and VAPAHCS Directors concurred with the findings and recommendation. The inspection checklist has been updated, and all inspectors were notified of the requirement for weekly inventories. The local CS policy, training materials, and the continuing education program for

inspectors will be updated. The target date for completion is June 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Number of Controlled Substances Inspectors. An adequate number of inspectors had not been appointed to sufficiently support the CS inspection program. VAPAHCS CS inspection policy specified that a minimum of 67 inspectors are required for the program. During our site visit, there were about 43 inspectors available to support the CS inspection program.

Recommendation 5 We recommended that the VISN Director require that the VAPAHCS Director appoints a sufficient number of CS inspectors to ensure that all program requirements are met.

The VISN and VAPAHCS Directors concurred with the finding and recommendation. The VAPAHCS will appoint and train additional inspectors. Target date for completion is June 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Controlled Substances Inspectors' Appointments. A number of inspectors who had recently completed their 3-year term had been reappointed as regular inspectors or back-up inspectors. This practice appears to be in conflict with the current national policy that inspectors' appointments should not exceed the 3-year term. There is no provision in the national policy for reappointing CS inspectors. In addition, not all inspectors had completed the annual CS certification in 2007 or possessed current letters of designation.

Recommendation 6 We recommended that the VISN Director require that the VAPAHCS Director ensures that CS inspector reappointments comply with the national policy and that all CS inspectors have completed the required annual certifications and possess current letters of designation prior to conducting inspections.

The VISN and VAPAHCS Directors concurred with the findings and recommendation. Inspectors who have completed or exceeded the 3-year term have been released. The program manager will ensure that annual certifications and designation memorandums are completed. The target date for completion is May 31, 2008. The improvement plan

is acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes in an acute inpatient medicine and surgery unit, the intensive care unit (ICU), a locked mental health inpatient unit, and a long-term care unit. We found adequate management of medications brought into the facility by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. We found one area that needed improvement.

Documentation of Pain Medication Effectiveness. In all the units we reviewed, nurses did not consistently document the effectiveness of pain medications, as required by VAPAHCS policy and nursing guidelines. Nursing guidelines require the pain scale levels to be documented as the measurement of pain medication effectiveness. VAPAHCS policy requires pain medication effectiveness to be documented within 60 minutes.

We reviewed the Bar Code Medication Administration records for 25 patients who were hospitalized in selected units at the time of our visit. Nurses administered a total of 66 doses of pain medications to these patients. For each patient, we reviewed documentation for several doses of pain medication. We found that all had comments documented in the records related to the effectiveness of the pain medication. However, the effectiveness of pain medication using the pain scale was not documented in 21 of 66 total doses (32 percent). In 26 of 66 doses (39 percent), the effectiveness was not documented within 60 minutes, as required. Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 7 We recommended that the VISN Director ensure that the VAPAHCS Director requires that nurses consistently document the effectiveness of all pain medications, including the corresponding pain scale levels, within the required timeframe.

The VISN and VAPAHCS Directors concurred with the findings and recommendation. The VAPAHCS will develop a written policy for reassessment of pain medication effectiveness and a monitoring tool to assess effectiveness using pain scale levels. All licensed nursing staff will receive training on the required documentation. The target date for completion is September 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine if the VAPAHCS complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff.

We evaluated more than 20 patient care areas at the Livermore, Menlo Park, and Palo Alto divisions. We conducted onsite inspections of outpatient care areas (primary and specialty care clinics and surgery); the ED; inpatient medical-surgical (2A, 3C), intensive care (medical surgical ICU, intermediate ICU), sub-acute (4C), nursing home (Bldg. 90, Bldg. 324), mental health (2B1, 2B2, 5, 5B3, Bldg. 348), rehabilitation (Bldg. 7, Bldg. 48, MB2), and transitional care (331) units; and procedure suites (dialysis, radiology, and gastrointestinal).

On the locked mental health units (2B1, 2B2), managers had generally evaluated and addressed safety issues, as required. In addition, we found that staff had received the required environmental safety training. For two items that did not meet current requirements (installing appropriate sprinkler heads and securing furniture in hallways and day rooms) managers had documented action plans with target dates for completion.

Overall, we found the areas we inspected to be generally clean and well maintained. However, we identified conditions that required managers' attention, such as untagged exercise equipment, a dirty refrigerator and microwave, bathrooms that needed thorough cleaning, and walls in some areas that needed repainting. Managers took immediate actions to address these deficiencies. We also found that ear flushing treatments were done in the general dining area at the nursing home unit in Livermore. Managers agreed to find a more suitable place to perform these treatments. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the VAPAHCS had developed staffing guidelines for nurse staffing, and we found them to be adequate.

The VAPAHCS uses hours per patient day (HPPD) as the primary staffing methodology. The exception was the EC Service where a more static methodology was utilized. We suggested that the EC Service be more prescriptive in how they document their staffing methodology. The EC Manager promptly revised the staffing documents to help clarify the allocation of nursing staff.

We reviewed staffing for 10 inpatient units for 44 total shifts. We found that guidelines for nurse staffing were generally met in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of supplemental nurses when needed. Overall, we found that according to the HPPD model, the VAPAHCS had adequate nursing staff. Therefore, we made no recommendations.

Emergency Department Operations

The purpose of this review was to evaluate whether VHA facility EDs complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the VAPAHCS ED and triage environments for cleanliness and safety.

The VAPAHCS ED is open 24 hours per day 7 days per week, as required for an ED. The ED is located within the main hospital building, and emergency services provided are within the facility's patient care capabilities. In addition, the

VAPAHCS has an appropriate policy for managing patients whose care may exceed the facility's capability.

We reviewed the medical records of 10 patients who presented in the ED with acute mental health conditions, and in all cases, we found that patients were managed appropriately. In addition, we determined that four patient transfers complied with applicable policy.

We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also found that managers had appropriately documented demonstrated nursing competencies. We made no recommendations.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figure 1 on the next page shows the VAPAHCS's patient satisfaction performance measure results for inpatients, and Figure 2 on the next page shows the VAPAHCS's patient satisfaction performance measure results for outpatients. The VAPAHCS's inpatient and outpatient scores exceeded the target in all 4 quarters. We made no recommendations.

Figure 1:

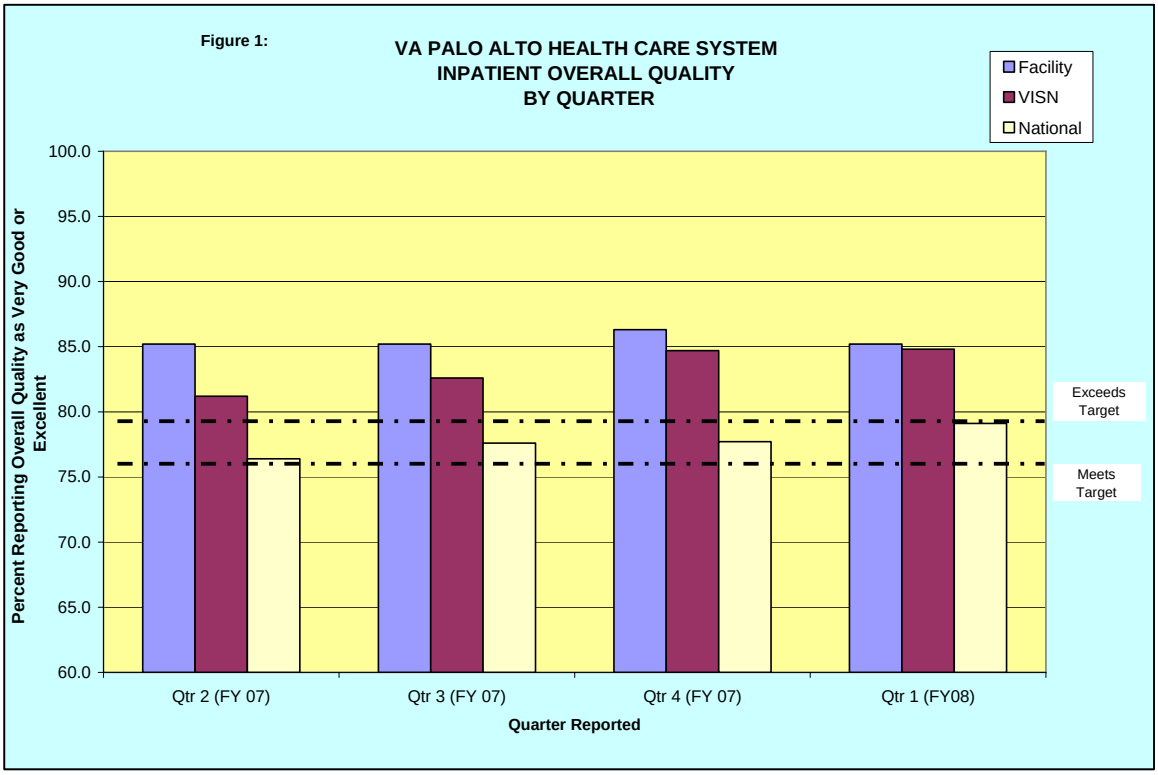
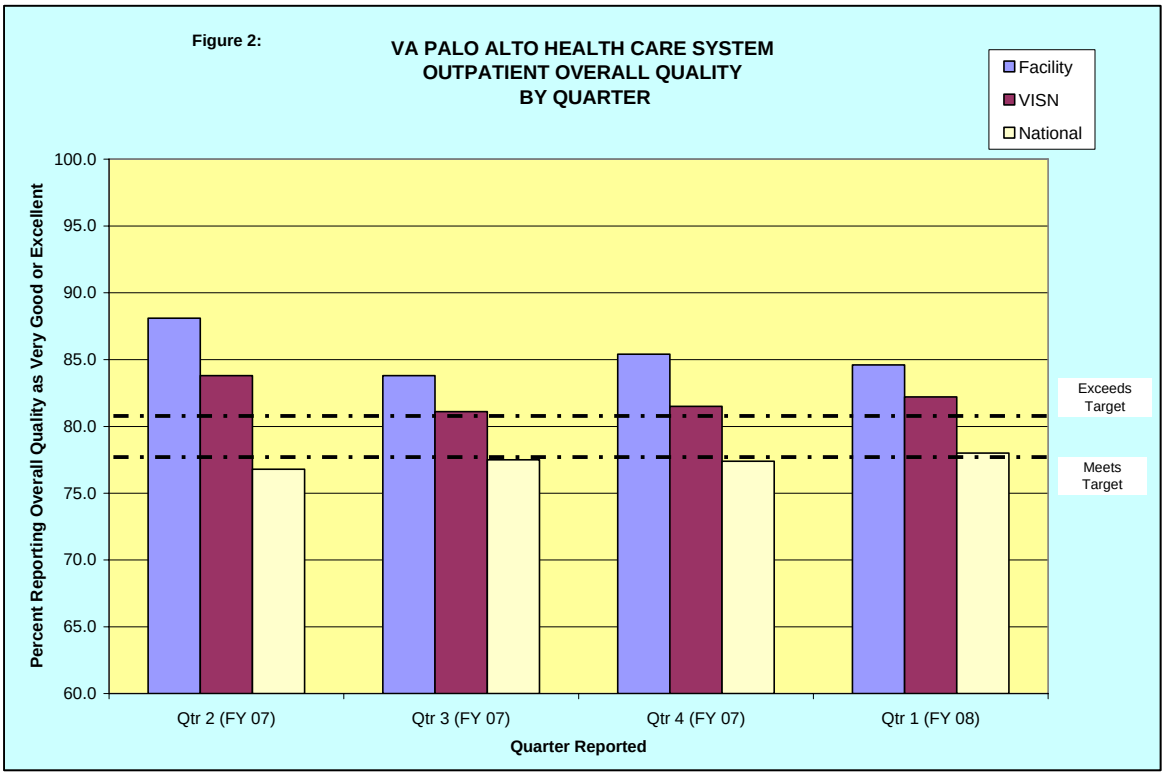


Figure 2:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 7, 2008

From: VISN Director (10N21)

Subject: **Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California**

To: Director, Los Angeles Office of Healthcare Division (54LA)

Director, Management Review Service (10B5)

Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VA Palo Alto Health Care System (VAPAHCS) conducted on March 3–6, 2008. We concur with the recommendations and will ensure that they are completed as described in the attached plan by the established target dates.

If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (707) 562-8350.

(original signed by:)

Robert L. Wiebe, M.D., M.B.A.

Attachment

Health Care System Director Comments

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 VAPAHCS Director requires that the Medical Staff Coordinator, in conjunction with all clinical service chiefs, review all physicians' privileges to ensure that current privileges match current work, privileges are signed off by the appropriate chief(s), all reference sources (documents, paperwork, computer programs) reflect correct privileges, and changes in work assignments at any time are accompanied by commensurate privilege changes.

Concur.

Target Date of Completion/Implementation: September 30, 2008

Planned Action: All applicable physicians credentialing and privileging folders will be reviewed. The Medical Staff Office (MSO), in conjunction with service chiefs, will ensure that the current privileges match current work. If necessary, MSO will mail packets to update privileges to appropriate physicians. These packets will be reviewed at the VAPAHCS PSB/MEB meetings for approval. These changes will be reflected in all reference sources no later than September 30, 2008. The MSO, in conjunction with service administrative officers, will ensure that service chiefs review all privileges requested by providers working in their service during initial and reappointments. Any recommended/required changes will be relayed directly to the provider and MSO by the service chief by September 30, 2008.

Recommendation 2. We recommended that the VISN Director ensure that the VAPAHCS Director requires that appropriate managers develop a mechanism to discuss all cases where review processes might identify adverse events so cases can be considered for disclosure and that full disclosure is documented, as appropriate.

Concur.

Target Date of Completion/Implementation: May 31, 2008

Planned Action: VAPAHCS' electronic adverse event disclosure template previously did not include clinical disclosure. This template has been revised to capture both clinical and institutional disclosures. All practitioners will be required to document unanticipated events using the new template, "CLINICAL AND INSTITUTIONAL ADVERSE EVENTS REPORTING," found in CPRS. An alert will automatically be sent to the Quality Management Risk Manager each time the template is used. The Risk Manager will review all disclosures and discuss with Senior Management to determine whether an institutional or large scale disclosure is warranted. An addendum will be entered by the Risk Manager when Institutional disclosure has been made that will include advisement of the patient's right to file a claim or file for increased benefits. Training of staff regarding use of the new template and VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, is currently underway and will be completed with full implementation of the new template by May 31, 2008.

A web-based (Intranet), "Adverse Event Disclosure" template has been developed as a tool for anyone in the health care system to report real or potential adverse events, close calls, etc. The Risk Manager will review all submissions to the webpage and discuss with senior management to determine the type of disclosure and documentation required. Staff training regarding use of the webpage is underway and will be completed with full implementation of the webpage by May 31, 2008.

Recommendation 3. We recommended that the VISN Director ensure that the VAPAHCS Director requires clinical service chiefs to develop plans for continuous performance review, including provider-specific QM/PI results, and maintain provider profiles that demonstrate that the plans are being followed.

Concur**.**

Target Date of Completion/Implementation: July 31, 2008

Planned Action**:** VAPAHCS will issue a Health Care System Memorandum by May 31, 2008, to require all clinical services to develop a plan that will incorporate elements for continuous performance review that will be monitored quarterly by the Medical Staff Office (MSO) for each provider according to their specialty. Plans will be developed and implemented by July 31, 2008.

Recommendation 4. We recommended that the VISN Director ensure that the VAPAHCS Director requires that weekly inventory checks be performed in all appropriate areas and that the checklist and the local policy are updated to reflect this requirement.

Concur.

Target Date of Completion/Implementation: June 30, 2008

Planned Action: The Inspection Checklist that is completed by Controlled Substance Inspectors has been updated to include verification of the nursing weekly inventories. All inspectors have been notified by email of this requirement and provided an updated copy of the checklist. This facet of the inspection program will be added to local policy, all training materials for new inspectors, and our continuing education program for inspectors by June 30, 2008.

Recommendation 5. We recommended that the VISN Director require that the VAPAHCS Director appoints a sufficient number of CS inspectors to ensure that all program requirements are met.

Concur.

Target Date of Completion/Implementation: June 30, 2008

Planned Action: VAPAHCS will appoint and train additional inspectors to ensure that all program requirements are met by June 30, 2008.

Recommendation 6. We recommended that the VISN Director require that the VAPAHCS Director ensures that CS inspector reappointments comply with the national policy and that all CS inspectors have completed the required annual certifications and possess current letters of designation prior to conducting inspections.

Concur.

Target Date of Completion/Implementation: May 31, 2008

Planned Action: Any Inspector that has met or exceeded the 3-year term has been released. While we cannot correct the certifications and designation memorandums for 2007, we will ensure that annual certifications and designation memorandums are complete by May 31, 2008 for all current and future inspectors.

Recommendation 7. We recommended that the VISN Director ensure that the VAPAHCS Director requires that nurses consistently document the effectiveness of all pain medications, including the corresponding pain scale levels, within the required timeframe.

Concur.

Target Date of Completion/Implementation: September 30, 2008

Planned Action: Establish a written policy for reassessment of pain effectiveness based on expert input and review with nurse and pharmacy leaders by April 30, 2008. VAPAHCS will develop a monitoring tool to assess the effectiveness of pain medications using pain scale levels for responsive patients within the required timeframe by May 31, 2008.

VAPAHCS will develop a pain effectiveness training module to be used for new nursing orientation and for all licensed staff as a mandatory annual review and additionally part of new BCMA nursing orientation by May 31, 2008. VAPAHCS will provide training for every licensed nursing staff on the requirements for timely documentation and type of documentation. This training will be completed by September 30, 2008.

OIG Contact and Staff Acknowledgments

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