Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-01745-201

Combined Assessment Program Review of the VA Northern California Health Care System Sacramento, California

September 11, 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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Table of Contents

Page

Executive Summary i

Introduction 1
Profile............ 1
Objectives and Scope 2

Organizational Strengths............ 3

Results 4
Review Activities With Recommendations 4
Quality Management 4
Pharmacy Operations and Controlled Substances Inspections............ 6
Environment of Care............ 7
Emergency Department and Urgent Care Center Operations 9
Medication Management 10
Coordination of Care 11
Review Activities Without Recommendations 12
Patient Satisfaction Survey Scores............ 12
Staffing 13

Appendixes
A. VISN Director Comments 14
B. Health Care System Director Comments............ 15
C. OIG Contact and Staff Acknowledgments 20
D. Report Distribution............ 21

Executive Summary

Introduction

During the week of July 14–18, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Northern California Health Care System (VANCHCS), Sacramento, 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 472 employees. The VANCHCS is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

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

- Emergency department (ED) display board.
- Operating room (OR) slider board.
- Evidence-based cancer patient management models.

We made recommendations in six of the activities reviewed. For these activities, the VANCHCS needed to:

- Implement a consistent data gathering, analysis, and reporting process; document discussions about data analyses; and evaluate actions to address problems or trends.
- Initiate a process for comprehensive monitoring of medication reconciliation.
- Ensure that controlled substances (CS) program oversight is effective and that monthly inspections comply with Veterans Health Administration (VHA) regulations.
- Require that competency assessments of all CS inspectors are completed.
- Address identified security and safety issues and implement action plans accordingly.
- Require compliance with VHA and VANCHCS inter-facility transfer policy and ensure that patient transfers are monitored and evaluated.
- Ensure that nurses consistently document the effectiveness of all pain medications within the required timeframe.

- Ensure that nurses document patient understanding of discharge instructions.

The VANCHCS complied with selected standards in the following activities:

- 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 VANCHCS Directors concurred with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 14–19, for the full text of the Directors' comments.) We will follow up on 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 VANCHCS is a two-division facility in California that provides inpatient and outpatient health care services. It operates two inpatient divisions—one in Mather (the Sacramento division) and one in Martinez (the East Bay division). Outpatient care is provided at both divisions and at six outpatient clinics (OPCs) in Chico, Fairfield, McClellan, Oakland, Redding, and Vallejo, CA. The VANCHCS is part of VISN 21 and serves a veteran population of more than 377,000 throughout 17 counties in California.

Programs. The VANCHCS provides medical, surgical, primary, mental health, extended care, and rehabilitation services. It has 50 hospital beds and 120 rehabilitation and extended care beds.

Affiliations and Research. The VANCHCS's primary academic affiliation is with the University of California's Davis School of Medicine. It supports 375 medical resident positions. The VANCHCS is also affiliated with several colleges that provide clinical training for allied health, nursing, and optometry students. In FY 2007, the VANCHCS's research program had 130 projects and grant awards of $29.9 million. Important areas of research include Alzheimer's disease, arthritis, cardiac disease, traumatic brain injury, and wound healing.

Resources. In FY 2007, the medical care operating budget was $340.1 million, and medical care expenditures totaled $335.5 million. The FY 2008 medical care operating budget is $391 million. FY 2007 staffing was 1,686 full-time employee equivalents (FTE), including 176 physician and 434 nursing FTE.

Workload. In FY 2007, the VANCHCS treated 70,695 unique patients. The inpatient care workload totaled 3,770 discharges, and the average daily census, including community living center (CLC)[1] patients, was 138.9. Outpatient workload totaled 703,211 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

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 patients, managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care.
- ED and Urgent Care Center (UCC) Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations and CS Inspections.
- QM.
- Staffing.

The review covered VANCHCS operations for FY 2007 and FY 2008 through July 18, 2008, 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 VANCHCS (*Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, California,* Report No. 05-00735-160, June 27, 2005). The VANCHCS had addressed all findings

related to pressure ulcer management from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 472 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

Emergency Department Display Board

In order to improve patient flow in the ED, clinicians implemented an electronic ED display board. The board provides clinicians with a log of current patient information that can be updated to reflect any change in a patient's acuity, status, or location. In addition to tracking a patient's progress across a continuum of care, the board provides a way to collect data that allows clinicians to identify areas needing improvement. Over the 7 months that the VANCHCS has utilized the board, clinicians have been able to measure the number of patients residing in the ED for more than six hours, identify the areas of inefficiency, and significantly improve patient "throughput"—the time in which patients move into, through, and out of the ED.

Operating Room Slider Board

The OR team has developed and implemented a slider board in the OR for all the elements of the "time-out" (immediate pre-operative pause) process to ensure correct person, correct site, and correct surgery. Prior to the initiation of the slider board, the VANCHCS had one near miss wrong-site surgery. Since the slider board's inception, there have been no wrong-site, no wrong patient, and no incorrect implant surgical events. In addition, the VANCHCS's performance measure score for timely initiation of antibiotics prior to surgical incision has improved from 67 percent to 100 percent.

Evidence-Based Cancer Patient Management Models

Patients on oral chemotherapy, a new area of oncology treatment, do not undergo traditional treatments and need to be managed appropriately. Using evidence-based practices, Hematology-Oncology (Hem-Onc) staff developed improved models for these complex cancer patients, such as case management to monitor patients' symptoms and compliance with treatments, distribution of home chemotherapy waste kits to ensure proper disposal, and use of an electronic teaching form to augment nursing notes. In addition, oncology pharmacist and Hem-Onc staff jointly developed a comprehensive chemotherapy order set that includes more than 60 treatment regimens. For these improvements, Hem-Onc staff received recognition from a local oncology nursing society.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the VANCHCS's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the VANCHCS Director, Chief of Staff, and Chief of QM. We also 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 VANCHCS's quality of care. Appropriate review structures were in place for 13 of the 15 program activities reviewed. However, we identified two areas that needed improvement.

<u>Data Gathering, Analysis, and Reporting</u>. Data gathering, analysis, and reporting are required in many QM and performance improvement areas. Although we found evidence of data gathering in many required areas, gaps were noted in some areas. Also, improvement was needed in documenting discussions about data analyses that were presented in committee and council meetings.

For example, although data regarding patient discharge times were gathered and analyzed, we did not find documentation that the data were discussed in meeting minutes or that actions were taken. We were told that detailed discussions took place at the meetings but were not

documented in the minutes. Another example is the critical values reporting agenda item. This important issue was discussed occasionally at Clinical Advisory Committee meetings, but no recommendations or strong actions were documented to address this issue for more than a year.

Managers had recently realigned the committee structure to reduce duplication and improve effectiveness.

Recommendation 1 We recommended that the VISN Director ensure that the VANCHCS Director requires that service chiefs, program coordinators, and committee chairpersons assure consistent data gathering, analysis, and reporting; document discussions about data analyses; and implement and evaluate actions to address problems or trends.

The VISN and VANCHCS Directors concurred with the findings and recommendation. Managers have implemented a new committee structure to ensure consistent data management and standardized meeting activities. VANCHCS senior executives will identify reporting and report tracking responsibilities for each committee. Training has begun, and all committees are to be restructured and operational by November 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Medication Reconciliation. This topic is a national patient safety goal that requires each facility to maintain a list of all medications each patient takes. This list must be reviewed at key points during each patient's care, such as admission, transfer, and discharge. Any duplications, omissions, or potentially hazardous combinations must be addressed or reconciled.

We noted that comprehensive monitoring of medication reconciliation ceased when a key staff person was reassigned. Subsequently, only medication reconciliation in the OPCs has been monitored. A spot audit conducted while we were onsite indicated good performance. However, managers needed to ensure that a process for comprehensive monitoring is maintained.

Recommendation 2 We recommended that the VISN Director ensure that the VANCHCS Director requires that a process for

comprehensive monitoring of medication reconciliation is initiated and maintained.

The VISN and VANCHCS Directors concurred with the findings and recommendation. A comprehensive process for monitoring medical reconciliation has been re-initiated. The inpatient pharmacy supervisor will monitor completion rates, and the Provision of Care Functional Team will analyze and track reports. The target date for completion is November 30, 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 pharmacies' 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.

We reviewed VHA regulations governing pharmacy and CS security, and we assessed whether the facility's policies and practices were consistent with VHA regulations. We inspected the pharmacies for security, EOC, and infection control (IC) issues.

The VANCHCS had appropriate policies to ensure the security of the pharmacies and CS. Managers had developed effective processes to ensure that clinical pharmacists identified patients who were receiving multiple prescription medications, reviewed their medication regimens to avoid polypharmacy, and appropriately advised providers.

The pharmacies' internal environments were clean and well maintained. The annual physical security surveys of all VANCHCS pharmacies had been conducted, as required, and all recommendations had been addressed. We identified improvement opportunities in the following areas:

Monthly Inspections. During the first 6 months of FY 2008, three CS storage areas did not receive the required monthly inspections, several inspectors conducted CS inspections with expired letters of designation, one inspector inappropriately inspected one storage area for 2 consecutive months, and managers did not review or concur with the monthly CS inspection reports in a timely manner. VANCHCS managers had recently begun to address these

issues by taking actions to strengthen oversight of the CS inspection program. However, managers needed to ensure that actions taken are effective and that compliance with the monthly inspections is maintained.

Recommendation 3

We recommended that the VISN Director ensure that the VANCHCS Director requires program managers to ensure that CS program oversight is effective and that monthly inspections comply with VHA regulations.

The VISN and VANCHCS Directors concurred with the findings and recommendation. Managers have allocated additional resources to the CS program to ensure that oversight and inspection activities adhere to VHA regulations. The target date for completion is November 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Competency Assessments. Program managers had developed a comprehensive competency assessment checklist to ensure that inspectors have received the appropriate orientation and training to successfully perform their duties. We found that competency assessments for several inspectors had not yet been completed and that these individuals had already conducted inspections independently. Program managers assured us that these inspectors had been previously trained. However, without written documentation of demonstrated competencies, managers could not be assured that these inspectors have the necessary skills or training to successfully assume their inspection responsibilities.

Recommendation 4

We recommended that the VISN Director require that the VANCHCS Director ensures that competency assessments for all CS inspectors are completed.

The VISN and VANCHCS Directors concurred with the findings and recommendation. Managers have started taking actions to ensure that competency assessment evaluations of inspectors are completed by November 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the VANCHCS complied with selected IC standards and maintained a clean, safe, and secure 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 inspected the OPC in Oakland and the OPC and the Center for Rehabilitation and Extended Care (CREC) in Martinez. At the Sacramento division, we inspected all inpatient units and selected outpatient and specialty care areas (ambulatory surgery, dermatology, primary care, women's health, and mental health clinics).

Overall, we found the areas we inspected to be generally clean and well maintained. We identified conditions that required managers' attention, such as soiled ceiling tiles, a dirty microwave, and a leaky faucet. Managers took immediate actions to correct these deficiencies. We identified the following issues that needed improvement:

Security and Safety Issues. At several VANCHCS sites, we found that police officers did not consistently perform the required monthly alarm testing. The Chief of Police informed us that all divisional supervisors will be required to attest by electronic mail (on the 25th day of each month) that the monthly alarm testing has been conducted.

During our tour of the Sacramento Division, we found unsecured access to a soiled utility room and supplies (scalpels and other items) and unprotected patient information in the OPC areas. Managers provided us with action plans to address these issues.

Recommendation 5 We recommended that the VISN Director require that the VANCHCS Director ensures that identified security and safety issues have been addressed appropriately and that action plans have been implemented.

The VISN and VANCHCS Directors concurred with the findings and recommendation. Managers have implemented actions that include monthly testing of alarms, installing a key punch lock in the soiled utility room, securing supply storage

areas, and developing a policy for protecting health information. The Environment of Care Functional Team will monitor compliance on a quarterly basis. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Emergency Department and Urgent Care Center Operations

The purpose of this review was to evaluate selected aspects of care and operations in VHA EDs and UCCs, such as clinical services, consults, inter- and intra-facility transfers, staffing, and staff competencies. We also determined if the physical environments were clean and safe and if managers maintained equipment appropriately.

We interviewed program managers from the Oakland and Martinez UCCs and from the ED at the Sacramento division. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. Additionally, we interviewed VANCHCS transfer coordinators (clinical and administrative) and reviewed medical records of patients who were transferred to other medical facilities or to inpatient units within the VANCHCS.

Our review showed that clinical services, consults, staffing, and nursing staff competencies were appropriate at all three locations. The ED is open 24 hours per day, 7 days per week, as required for an ED. Emergency services provided are within the Sacramento division's patient care capabilities. In addition, we found appropriate policies for managing patients whose care may exceed that division's capability.

We conducted EOC tours and found that the areas were clean and safe and that equipment was appropriately maintained. However, we did not find signage at the Oakland and Martinez facilities that would readily identify the presence and location of the UCCs at these sites. Managers assured us that signage had been ordered and will be installed. In addition, we found what appeared to be inappropriate clinical privileges granted to two of the three providers at the Oakland OPC. These providers were privileged to perform endotracheal intubation, which appeared to be beyond the scope of service designated for this clinic. Managers agreed to review the appropriateness of clinical privileges granted to UCC providers. Since managers were in the process of taking corrective actions, we did not make any recommendations related to these findings. However, the following area needed improvement:

Inter-Facility Transfers. We reviewed the medical records of six patients transferred from the UCCs to other medical facilities for care. Transfer documentation did not consistently comply with VHA regulations or the VANCHCS's inter-facility transfer policy, which require the use of VA Form 10-2649A ("Inter-Facility Transfer Form") and/or the appropriate electronic medical record template note.

In addition, we did not find evidence that patient transfers were monitored and evaluated as part of the VANCHCS's QM program, as required. Managers updated the local policy while we were onsite and informed us that they will conduct quarterly audits of patient transfers and report findings to the appropriate VANCHCS committee.

Recommendation 6

We recommended that the VISN Director ensure that the VANCHCS Director requires that all inter-facility transfer documentation comply with VHA and VANCHCS policy and that patient transfers are monitored and evaluated.

The VISN and VANCHCS Directors concurred with the findings and recommendation. The VANCHCS inter-facility transfer policy has been updated, and staff education on the use of the appropriate VA forms has begun. The utilization review nurse will review 20 records monthly to track compliance. 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, the transitional care unit, and rehabilitation and extended care units. 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 identified one area that needed improvement.

Timeliness of Documentation of Pain Medication Effectiveness. In all the units we reviewed, nurses consistently documented the effectiveness of pain medications administered to patients. However, nurses did not document the effectiveness of these medications within 2 hours of administration in over half of the doses

administered during the week May 25–31, as required by VANCHCS policy. Of the 764 doses of pain medications administered, only 45 percent (343/764) were documented within the required timeframe (the VANCHCS's goal is 85 percent). Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed. Managers informed us that more recent reviews have shown significant improvements.

Recommendation 7 We recommended that the VISN Director ensure that the VANCHCS Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe.

The VISN and VANCHCS Directors concurred with the finding and recommendation. Nursing staff education on timely documentation has been initiated. Daily reports will provide immediate feedback to nurses and managers. The Provision of Care Functional Team will be responsible for data analysis and follow-up actions. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Coordination of Care

The purpose of this review was to evaluate whether selected aspects of care, such as consultations, intra-facility transfers, and discharges, were coordinated appropriately over the continuum of care. Timely responses to consults, effective management of patient transfers, and appropriate discharge instructions are essential to optimal patient outcomes.

Overall, we found that inpatient consultations (69/70) and intra-facility transfers (10/10) were managed appropriately. However, we found that 35 percent (8/23) of nursing discharge instructions did not consistently contain documentation of verbalized patient understanding at discharge. Managers informed us that a "glitch" in the discharge template had been fixed, which will ensure that nurses' entries related to discharge instructions are documented.

Recommendation 8 We recommended that the VISN Director ensure that the VANCHCS Director monitors the effectiveness of actions taken and ensures that patient understanding of discharge instructions is documented, as required.

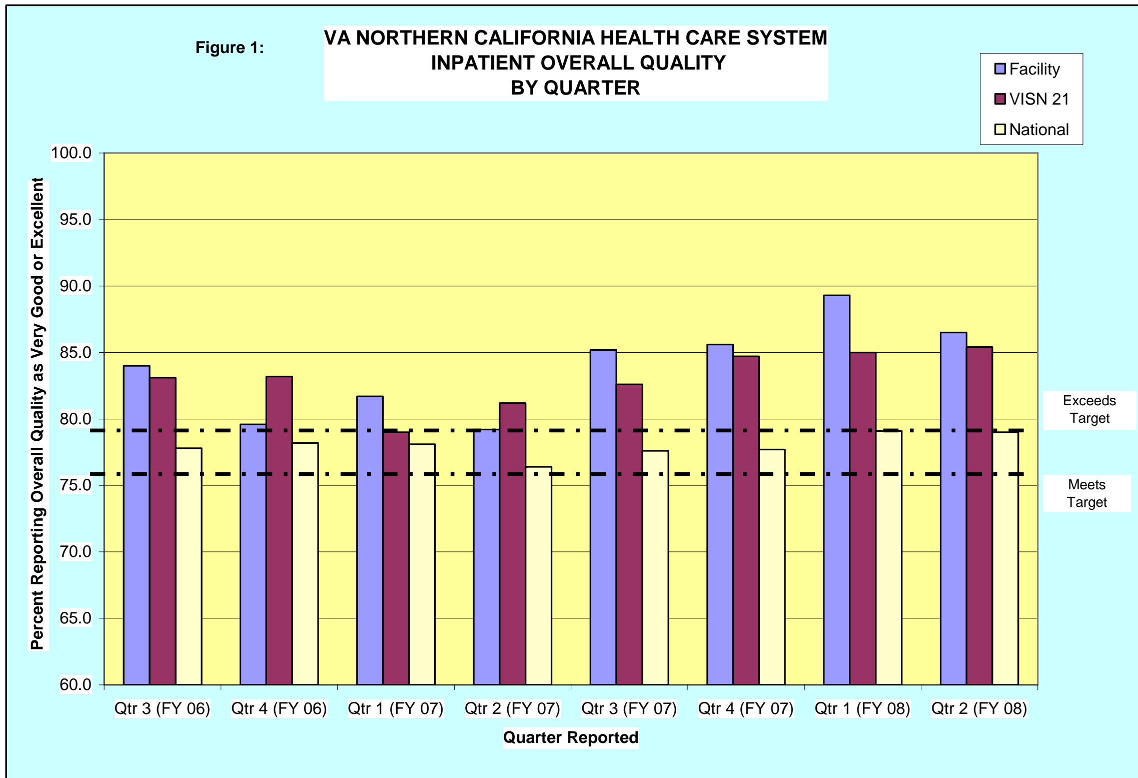
The VISN and VANCHCS Directors concurred with the findings and recommendation. The CLC/CREC discharge template has been revised, and the electronic inpatient discharge instruction menu has been updated to include the required documentation of patient understanding. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

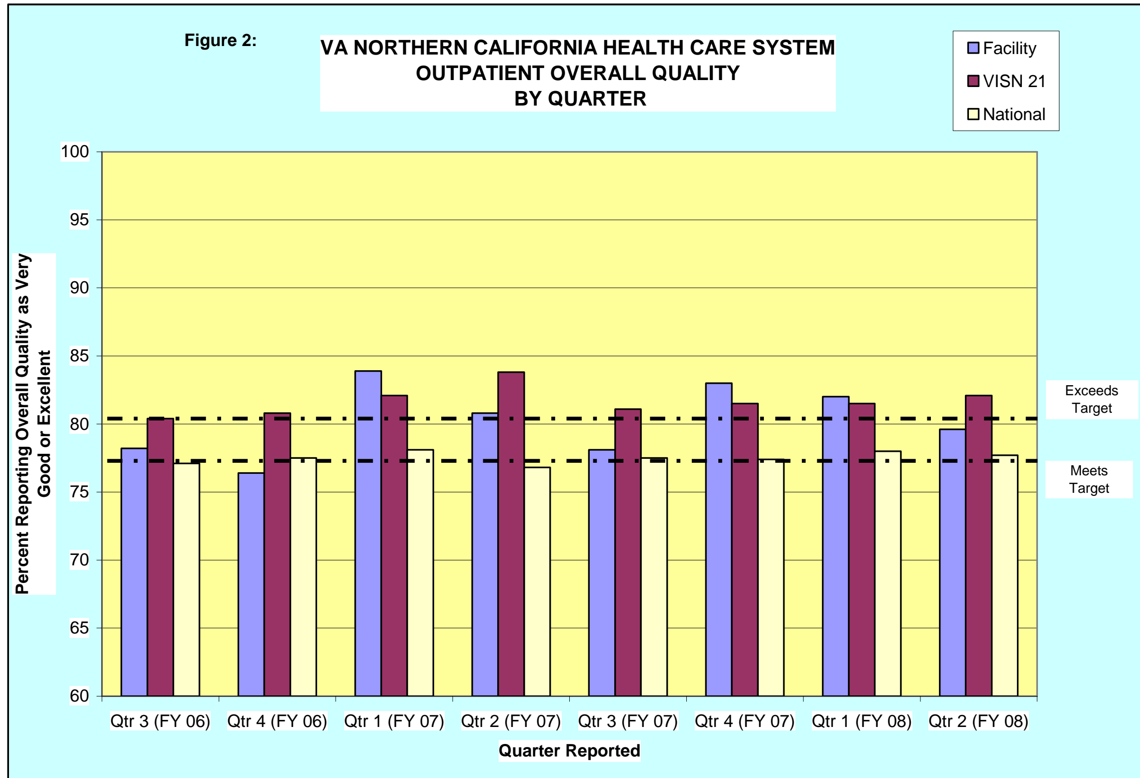
Review Activities Without Recommendations

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 percent for outpatients.

Figures 1 and 2 below and on the next page show the VANCHCS's patient satisfaction performance measure results for inpatients and outpatients. VANCHCS inpatient scores met or exceeded the target in all 8 quarters of available data, and outpatient scores met or exceeded the target in all but 1 quarter. 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 VANCHCS had developed staffing guidelines for nurses, and we found them to be adequate.

The VANCHCS uses "expert panel" as the primary staffing methodology. We reviewed staffing for six inpatient units for 64 total shifts. We found that nurse staffing requirements 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 the VANCHCS had adequate nursing staff. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2008

From: Director, VA Sierra Pacific Network, VISN 21 (10N21)

Subject: Combined Assessment Program Review of the VA Northern California Health Care System (612)

To: Director, Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VA Northern California Health Care System (612), July 14–18, 2008. We concur with the recommendations and will ensure that they are completed as described in the attached plan by the established target dates.

2. If you have any questions regarding the attached response or actions to the recommendations in the draft report, please contact Ms. Judy Daley, VISN 21 Quality Management Officer, at (775) 328-1774.

(original signed by:)

Sheila M. Cullen

Attachments

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2008

From: Director, VA Northern California Health Care System Director (612/00Q)

Subject: Combined Assessment Program Review of the VA Northern California Health Care System, Sacramento, California

To: Director, Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Service (10B5)

1. On behalf of VA Northern California Health Care System, I would like to thank you for the informative and constructive OIG CAP audit performed the week of July 14, 2008. Attached you will find comments, corrective action plans, and completion dates for each recommendation attached.

2. If you have questions or need additional information, please feel free to contact Sandra Murphy, Acting Quality Manager, at (916) 843-9035.

(original signed by:)

Brian J. O'Neill, M.D.

Attachment

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 VANCHCS Director requires that service chiefs, program coordinators, and committee chairpersons assure consistent data gathering, analysis, and reporting; document discussions about data analyses; and implement and evaluate actions to address problems or trends.

Concur.

Target date of completion: November 30, 2008

Planned Action: A new committee structure for NCHCS is being implemented by Senior Executives to improve committee effectiveness and ensure all elements of this recommendation are addressed. Applicable policies were updated to ensure standardization of agendas, minutes, and tracking logs. Senior executives are responsible for identifying reporting responsibilities for each committee, including which reports the committees are responsible for tracking. Training for staff responsible for chairing, facilitating, and recording meetings is ongoing. All committees are to be restructured and operational by November 30, 2008.

Recommendation 2. We recommended that the VISN Director ensure that the VANCHCS Director requires that a process for comprehensive monitoring of medication reconciliation is initiated and maintained.

Concur.

Target date of completion: November 30, 2008

Planned Action: Comprehensive monitoring of medication reconciliation for inpatients has been reinitiated at NCHCS. The inpatient pharmacy supervisor is tracking the completion rate of pharmacists obtaining medication history during the admission interview. The designated inpatient clinical pharmacist is tracking and trending reasons for being unable to obtain a patient's medication history. Completion of a discharge counseling note by a pharmacist or provider and the provision of a medication list to patients discharged from the medical center is also being

monitored. Reports are to be analyzed and tracked through the Provision of Care Functional Team.

Recommendation 3. We recommended that the VISN Director ensure that the VANCHCS Director requires program managers to ensure that CS program oversight is effective and that monthly inspections comply with VHA regulations.

Concur.

Target date of completion: November 30, 2008

Planned Action: NCHCS has expanded the resources dedicated to the oversight of the Controlled Substance Program to ensure adherence to VHA regulations governing Controlled Substance security.

a. Appointment letters have been completed for all CS inspectors. Assignment periods on appointment letters are closely monitored by the CS Coordinator and will be tracked through the Performance Improvement Committee.

b. Inspection areas with a shortage of CS inspectors have been identified. The number of appointed inspectors has increased from 36 to 42 to ensure full compliance. The number of active CS inspectors and areas inspected will be tracked through the Performance Improvement Committee.

c. Reports that were pending at the time of the OIG visit have been completed and routed through Senior Executives. Tracking of continued compliance will be quarterly through the Performance Improvement Committee.

Recommendation 4. We recommended that the VISN Director require that the VANCHCS Director ensures that competency assessments for all CS inspectors are completed.

Concur.

Target date of completion: November 30, 2008

Planned Action: All inspectors that have a pending competency assessment will have the assessment completed by November 30, 2008. As of August 1, 2008, no inspector has performed an inspection without a current competency evaluation. New inspectors will be trained and observed during their first inspection by the Controlled Substance Coordinator. Competency assessments will be completed annually.

Tracking of compliance with be at the Performance Improvement Committee.

Recommendation 5. We recommended that the VISN Director require that the VANCHCS Director ensures that identified security and safety issues have been addressed appropriately and that action plans have been implemented.

Concur.

Target date of completion: November 30, 2008

Planned Action:

a. Consistent performance of required monthly alarm testing: Monthly alarm tests are assigned to Divisional Supervisors and are routed to the Chief, Police Service, by the 25th day of the month, reflecting that all checklists are complete and have been received.

b. Unsecured access to a soiled utility room: Key punch lock was installed on July 24, 2008.

c. Unsecured supplies (scalpels and other items): All unsecured items have been secured. Weekly Environment of Care rounds now include ensuring appropriate storage of supplies.

d. The Environment of Care Functional Team has responsibility for tracking above items for continued compliance on a quarterly basis.

e. Unprotected patient information in the outpatient clinic areas: A Process Action Team for Protected Health Information has developed a policy memorandum on the proper procedures for securing protected health information in both secure and unsecured areas. Weekly Site Manager Privacy and Information Security rounds have been implemented at all sites. Compliance will be monitored through the Information Management Functional Team.

Recommendation 6. We recommended that the VISN Director ensure that the VANCHCS Director requires that all inter-facility transfer documentation comply with VHA and VANCHCS policy and that the patient transfers are monitored and evaluated.

Concur.

Target date of completion: November 30, 2008

Planned Action: Chief, BDMS, updated Policy BDMS-16 on July 15, 2008, to follow VHA Directive 2007-015. Staff education on the utilization of VA Form 10-2649A and B was initiated July 15. Twenty records per month are reviewed by the Utilization Review Nurse to track compliance, with analysis and evaluation reviewed by the Provision of Care Functional Team.

Recommendation 7. We recommended that the VISN Director ensure that the VANCHCS Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe.

Concur.

Target date of completion: November 30, 2008

Planned Action: The continuous education of nursing staff regarding timely documentation of PRN effectiveness within the established parameters has been implemented. The BCMA coordinator runs a daily report to provide immediate feedback to the nurses and the Nurse Managers. Data analysis and follow-up actions are reviewed through the Provision of Care Functional Team.

Recommendation 8. We recommended that the VISN Director ensure that the VANCHCS Director monitors the effectiveness of actions taken and ensures patient understanding of discharge instructions is documented, as required.

Concur.

Target date of completion: November 30, 2008

Planned Action: On July 15, 2008, the Community Living Center/CREC discharge template was revised to include an area for the patient's understanding of discharge instructions. The computerized inpatient discharge instruction menu was updated to include a required entry of the patient's understanding. Nursing staff have been educated on the changes in documentation. A monthly audit will be conducted with an analysis of data and follow-up actions to be completed through the Provision of Care Functional Team.

OIG Contact and Staff Acknowledgments

Contact	Julie Watrous, Director Los Angeles Office of Healthcare Inspections (213) 253-5134
Contributors	Daisy Arugay, Team Leader Gail Bozzelli Toni Woodard Mike Seitler, Supervisory Investigator, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Sierra Pacific Network (10N21)
Director, VA Northern California Health Care System (612/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: Wally Herger, Barbara Lee, Daniel E. Lungren, Doris O. Matsui, George Miller, Fortney Pete Stark, Ellen Tauscher, Mike Thompson

This report is available at http://www.va.gov/oig/publications/reports-list.asp.