Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-01428-11

Combined Assessment Program Review of the Wilmington VA Medical Center Wilmington, Delaware

October 21, 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 May 5–9, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Wilmington VA Medical Center (the medical center), Wilmington, DE. 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 64 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

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

- Ensure completion of all peer reviews within 120 days.
- Ensure that providers are privileged to perform procedures that are within the capability of the setting for which the privileges were requested and that all privilege actions are documented in the appropriate Executive Committee of the Medical Staff (ECMS) minutes.
- Ensure the completion of required RCAs.
- Require that moderate sedation and the use of reversal agents are monitored and reported to the appropriate committee.
- Require that all designated environment of care (EOC) team members participate in all EOC rounds and that all community based outpatient clinics (CBOCs) are inspected semi-annually.
- Reassess the number of employees needed to participate in annual fit-testing to support current infectious disease programs.
- Require that Emergency Department (ED) inter- and intra-facility medical record transfer documentation is complete.

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

- Pharmacy Operations.

- Computerized Patient Record System (CPRS) Business Rules.
- Survey of Healthcare Experiences of Patients (SHEP).

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

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted 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 for the open recommendations 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 Level 2 facility located in Wilmington, DE, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs in Vineland, Ventnor, and Cape May, NJ; and in Dover and Georgetown, DE. The medical center is part of VISN 4 and serves a veteran population of about 256,000 throughout Delaware and portions of southern New Jersey and southeastern Pennsylvania.

Programs. The medical center provides acute inpatient medical and surgical care and long-term care. It also provides a complete array of outpatient services, including primary care, medicine, surgery, behavioral health, neurology, oncology, dentistry, geriatrics, and rehabilitation. The medical center has 60 hospital beds and 60 community living center (CLC)[1] beds.

Affiliations. The medical center is affiliated with Thomas Jefferson University, the University of Medicine and Dentistry of New Jersey, the University of Maryland, the University of Delaware, and the Pennsylvania College of Optometry. It provides training for 31 residents, as well as other disciplines, including nursing, audiology, psychology, nutrition, and imaging.

Resources. In FY 2007, medical care expenditures totaled $110 million. The FY 2008 medical care budget is $115 million. FY 2007 staffing was 755 full-time employee equivalents (FTE), including 43 physician and 129 nursing FTE.

Workload. In FY 2007, the medical center treated 25,898 unique patients and provided 14,947 inpatient days in the hospital and 20,021 inpatient days in the CLC. The inpatient care workload totaled 2,651 discharges, and the average daily census, including CLC patients, was 94. Outpatient workload totaled 187,459 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 managers and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- CPRS Business Rules.
- ED Operations.
- EOC.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through May 5, 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 medical center (*Combined Assessment Program Review of the VA Medical Center, Wilmington, Delaware*, Report No. 05-01655-199, September 15, 2005). The medical center had corrected all findings related to health care from our prior CAP.

We also followed up on select recommendations from a report by the Veterans Health Administration's (VHA's) Office of the Medical Inspector (OMI) (*Final Report: Review of the Quality of Care, Nursing Home Care Unit, Wilmington VAMC, Wilmington, Delaware*, March 9, 2004). In that report, the OMI made recommendations to improve the quality of care at the Nursing Home Care Unit. In our review we found that the medical center now has a hospice unit, respite care, and is a designated community cancer center. We concluded that the medical center has carried out the recommendations found in the OMI report.

During this review, we also presented fraud and integrity awareness briefings for 64 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's Director, Chief of Staff, and Chief Nurse Executive, and we interviewed 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) policy.[2] Peer review is a confidential, non-punitive, and systematic process to evaluate the quality of care at the

[2] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[3] 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. We evaluated 11 peer reviews that were initiated since January 2007. All were completed within the 45-day timeframe. Final evaluations by the PRC should be completed within 120 days from the date of determination that a peer review is necessary. Five of the 11 peer reviews we evaluated were not completed within the 120 days. The medical center instituted new policies in January, and the PRC started meeting on a monthly basis. This has significantly improved the process.

Clinical Privileging. Clinical privileging includes a series of activities designed to collect relevant data and the decision-making process to assure that qualified health care professionals are providing the appropriate care in the appropriate setting. We reviewed the privileges granted to 10 providers, 3 of whom were surgeons. Two of the surgeons had been granted privileges to perform surgery beyond the capability of the outpatient setting for which they were granted. In addition, we found one contract provider who had not completely filled out the application for employment. Also, that provider's references from past employers were not favorable. VHA policy[4] requires that ECMS minutes reflect the documents reviewed and the rationale for the decision. No documentation of what was reviewed and no rationale for the decision to privilege this provider were found in the relevant committee minutes.

Root Cause Analysis. VHA policy[5] requires the medical center to complete RCAs, reviewing aggregate data for falls, adverse drug events, parasuicides, and elopements. During FY 2007, these RCAs were not completed by the medical center. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could

[3] 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.
[4] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[5] VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 30, 2002.
[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006

not be assured of a comprehensive and efficient patient safety process.

Moderate Sedation. Moderate sedation is a form of drug-induced depression of consciousness used to decrease pain and anxiety and to improve comfort for patients undergoing procedures or diagnostic treatments. Because of potential risk, VHA policy[6] requires the monitoring of compliance with defined protocols in all areas where moderate sedation is given. The Operative and Invasive Procedure Committee is the local oversight committee for analyzing data related to moderate sedation. We reviewed the committee minutes for FY 2007 and found that moderate sedation data had only been reported for the last 3 months of FY 2007. Also, no data was collected or reported on the use of reversal agents.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires completion of all peer reviews within 120 days.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to perform procedures that are within the capability of the setting for which the privileges were requested and that all privilege actions are documented in the appropriate ECMS minutes.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the completion of required RCAs.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation and the use of reversal agents are monitored and reported to the appropriate committee.

The VISN and Medical Center Directors concurred with the findings and recommendations and have implemented the following actions: (1) the PRC currently meets monthly; (2) the Physician Standards Board (PSB) and Clinical Executive Board (CEB) will more closely review privileges and practice settings, and documentation of discussion will be included in PSB and CEB minutes; (3) the Chief of QM meets weekly with the Patient Safety Manager to review RCA status, aggregate RCA outcomes is now a standing

agenda item at the Quality Leadership Board, and the medication aggregate RCA for FY 2008 is complete; and (4) moderate sedation data is being collected and reported through the Surgical Case Review Committee. The corrective actions for Recommendations 3 and 4 are acceptable, and we consider closed those recommendations closed. The implementation plans for Recommendations 1 and 2 are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the medical center maintained a safe and clean health care environment. The medical center is required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission standards. The infection control (IC) program was evaluated to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance.

We inspected the intensive care unit, the post-anesthesia care unit, the Sterile Processing Department, the dialysis unit, primary care clinics, medical-surgical units, and the ED. The medical center maintained a generally clean environment. We found that the IC program monitored and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. The following conditions required management attention.

Environment of Care Rounds. EOC rounds by the medical center's inspection team allow each discipline participating on the team to identify and correct discrepancies, unsafe working conditions, and OSHA regulatory violations. Representation from each discipline enables the team to cover the medical center in depth. Documentation of participation by each discipline's representative or designee on EOC rounds has been difficult to track. Also, CBOCs were not inspected semi-annually or with full team participation.

Respiratory Protection in Health Care. VHA policy for respirator fit-testing[7] directs medical centers to designate a minimum number of individuals required to support current infectious disease programs based on local needs and a clear strategy. Individuals identified to wear an N95 respirator[8] must undergo initial and annual fit-testing, training, and medical evaluation. Individuals identified to wear powered air purifying respirators[9] are exempt from fit-testing requirements but must complete the training and medical evaluation requirements.

The medical center has designated high-risk areas and identified a core group of individuals who need respirators. Three hundred ancillary employees have also been identified to participate in the fit-testing program. Due to the number of employees identified to participate in the program, safety and environmental staff are challenged to conduct fit-testing, perform training, and schedule medical evaluations for all employees annually.

Recommendation 5 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 6 We recommended that the VISN Director ensure that the Medical Center Director requires reassessment of the number of individuals needed to participate in annual respirator fit-testing to support current infectious disease programs.

The VISN and Medical Center Directors concurred with the findings and recommendations and have implemented the following actions (1) all EOC members are now required to sign in prior to EOC rounds, and the Dover CBOC, which opened May 22, has been added to the schedule and (2) the number of individuals required to participate in annual fit-testing was reassessed, resulting in the reduction of participants to 130. The corrective actions are acceptable, and we consider Recommendations 5 and 6 closed.

[7] OSHA Standard 1910.134, *Respiratory Protection*; VHA Health Information Letter 10-2005-023, *Respiratory Protection Used for Infectious Disease and Annual Fit-Testing*, December 1, 2005.

[8] Respirators filter the air you breathe to help protect you from microorganisms, including bacteria and many viruses. In health care settings, the most common type of respirator is a surgical N95 respirator.

[9] The powered air purifier respirator protects workers against particulates by drawing ambient air through a high efficiency particulate air or HEPA filter and supplying that air through a breathing tube into the hood and facepiece.

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, staffing adequacy, and staff competency. In addition, we inspected the medical center's ED environment for cleanliness and safety.

The 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 the emergency services provided are within the facility's capability. In addition, the medical center has an appropriate policy for managing patients whose care may exceed the facility's capability.

We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guideline for allocating nursing resources. We also found that managers had appropriately documented demonstrated nursing competencies.

We reviewed the medical records of three patient's who were transferred to another medical center for care. VHA's policy on inter-facility transfers requires that prior to a patient's transfer to another facility, the physician transferring the patient document the appropriate level of care required during transportation and designate an appropriately trained health care professional to provide that care. None of the medical records we reviewed had this documentation.

We also reviewed the medical records of five patients who were transferred from the ED to another unit in the medical center. None of these records contained evidence of a transfer report from the sending physician to the receiving physician. Joint Commission's National Patient Safety Goal 2E requires the sending physician to communicate relevant historical information concerning a patient to the receiving physician.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that inter- and intra-facility medical record transfer documentation is complete.

The VISN and Medical Center Directors concurred with the findings and recommendation and have communicated to the Administrative Officers of the Day and other providers the availability of the templated transfer note in CPRS and the requirement to use this note. Chart reviews and random chart audits will be conducted over a two-month period to

ensure compliance. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Review Activities Without Recommendations

Computerized Patient Record System Business Rules

The health record, as defined by VHA policy,[10] 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 times and dates recorded.

A communication (software informational patch 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 related to the editing of electronically signed documents in the electronic medical records system. 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, 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.

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 1907.01.

We made no recommendations.

[10] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Pharmacy Operations

The purpose of this review was to evaluate whether the medical center had adequate controls to ensure the security and proper management of controlled substances (CS) and the pharmacy's internal physical environment. We also evaluated whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of the pharmacy and CS. CS inspections were conducted according to VHA regulations, and training records showed that the CS coordinator and inspectors received appropriate training to execute their duties. Managers reported all CS diversions or suspected diversions to the OIG. The pharmacy's internal EOC was secure, clean, and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[11] Some literature suggests that that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[12]

We found that managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

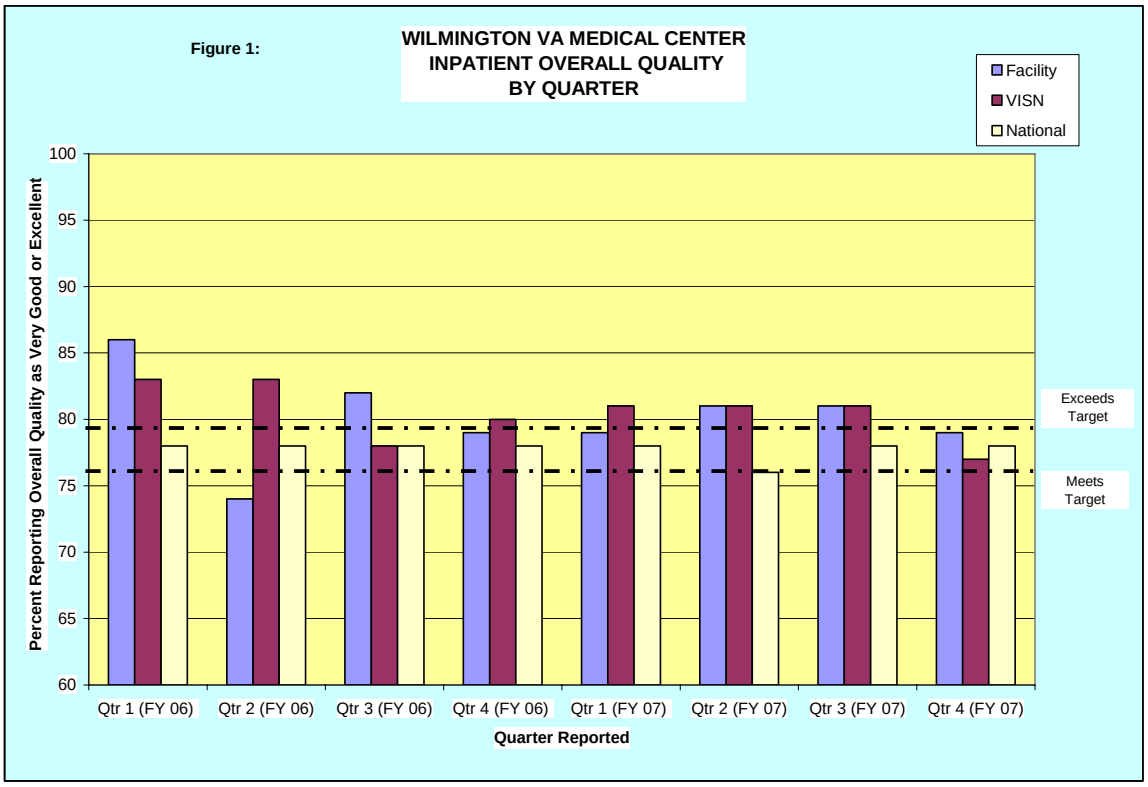
We made no recommendations.

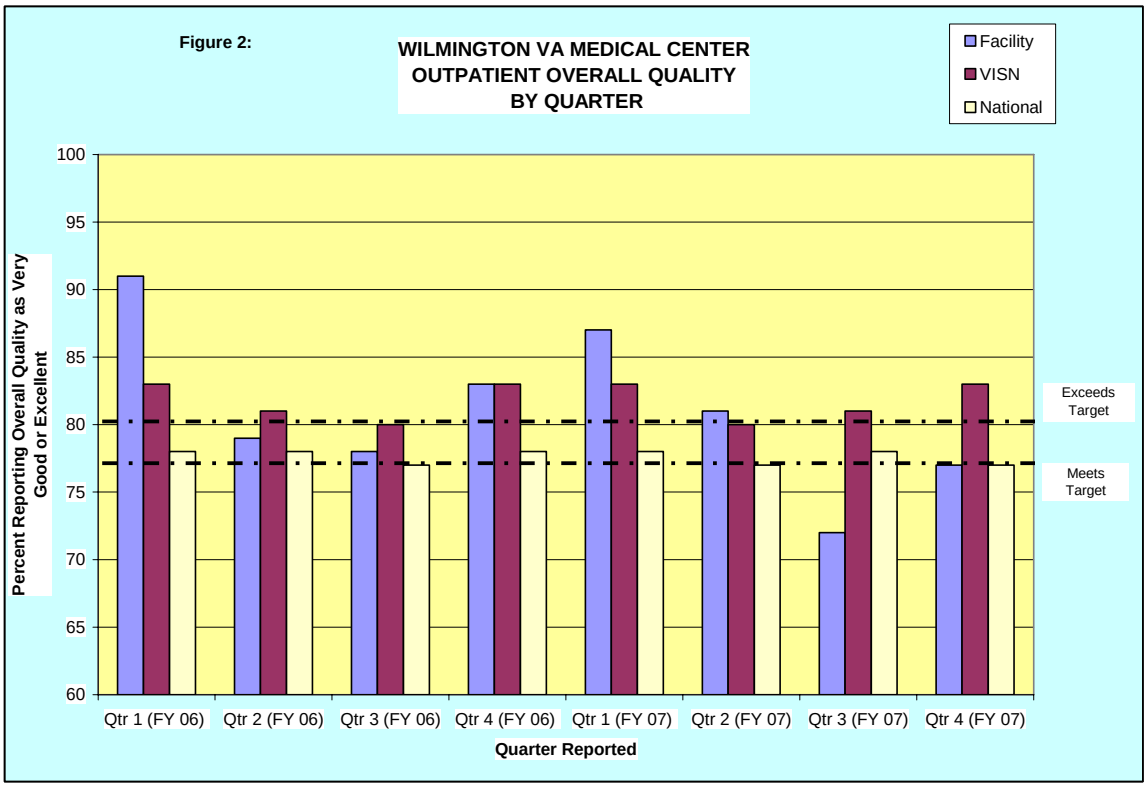
[11] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[12] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center used the quarterly/semi-annual survey report results of patients' health care experiences 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 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 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center met or exceeded the established target in 7 of the last 8 quarters of available data for inpatient and outpatient overall quality. The medical center also reviewed internal patient satisfaction data collected by the patient advocate, which was reported to the Quality Leadership Board and the Director's staff

We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **May 30, 2008**

From: Network Director, VA Healthcare VISN 4 (10N4)

Subject: **Draft Combined Assessment Program Review of the VA Medical Center (Wilmington, DE.)**

To: Director Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. I have reviewed the response to the OIG recommendations made by the Wilmington VA Medical Center and concur with all actions. We appreciate the opportunity for review of our processes at the medical center.

(original signed by:)

MICHAEL E. MORELAND, FACHE

Network Director

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: **May 30, 2008**

From: Director, Wilmington VA Medical Center (460/00)

Subject: **Combined Assessment Program Review of the Wilmington VA Medical Center, Wilmington, Delaware**

To: Network Director (10N4)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Wilmington VA Medical Center. We concur with the findings and recommendations and have processes in place to address the recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to our nation's veterans.

(original signed by:)

CHARLES M. DORMAN

Acting Medical Center Director

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 requires completion of all peer reviews within 120 days.

Concur

Target Completion Date: Complete

Wilmington recognized timeliness of peer reviews was extending beyond the 120-day limit. A self assessment was conducted on 2/25/08 by the Peer Review Committee as directed by the Acting Director. The committee identified the initial 45-day reviews were timely (100%); however, the 120-day committee reviews weren't being met (41%). In an effort to improve timeliness the committee agreed to meet monthly rather than quarterly. Since that time we have been meeting the 120-day limit (100%). We will continue to track and monitor all peer reviews. Data is submitted quarterly to VISN.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to perform procedures that are within the capability of the setting for which the privileges were requested and that all privilege actions are documented in the appropriate ECMS minutes.

Concur

Target Completion Date: June 2, 2008

Department Chairs have reviewed all current privileges for their departments to ensure privileges are approved in appropriate settings and for which the facility has resources to support. Any revisions will be reviewed and approved in Physician Standards Board (PSB) and Clinical Executive Board (CEB).

PSB/CEB members will review more closely privileges and practice settings recommended by the Department Chairs when approving privileges. Documentation of the discussion will be included in the PSB and CEB minutes.

Privilege delineation forms are being amended to include the following statement, which will be signed by applicable Department Chair: "My signature below indicates that I have reviewed this request for privileges within my department and have assigned appropriate practice settings. There is sufficient space, equipment, staffing and financial resources in place or available within a specified time frame to support each requested privilege. I certify that the applicant is competent to fulfill the obligations of medical staff membership at this hospital and the privileges and practice settings I have recommended above."

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the completion of required RCAs.

Concur

Target Completion Date: May 28, 2008

Chief of Quality Management is meeting weekly with Patient Safety Manager to review status of RCAs. Aggregate RCA outcomes are now a standing agenda item at Quality Leadership Board to ensure reporting and timely completion of required RCA's.

Medication aggregate RCA for FY08 is complete and was presented to Leadership 5/28/08.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation and the use of reversal agents are monitored and reported to the appropriate committee.

Concur

Target Completion Date: Complete

See Anesthesia Policy along with Surgical Case Review Committee (SCRC) scorecard. Data is being collected and reported through SCRC.

Recommendation 5. 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

Target Completion Date: Complete

See the attendance grid and schedule for EOC rounds. All EOC members are now required to sign in prior to EOC rounds. Dover CBOC opened 5/22/08 and has been added to the schedule.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires reassessment of the number of individuals needed to participate in annual respirator fit-testing to support current infectious disease programs.

Concur

Target Completion Date: Complete

The Chief of Staff, Infectious Control Practitioner, and Industrial Hygienist reassessed the number of individuals required to participate in annual respirator fit-testing. Total staff required has been reduced from over 300 to 130. This is a more manageable number to meet the annual respirator fit-testing requirements.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that inter- and intra-facility medical record transfer documentation is complete.

Concur

Target Completion Date: 5/28/08

Medical Director for the Emergency Department communicated to all AOD's regarding the availability of the templated transfer note in CPRS and the requirement to document all transfers utilizing this note. Communication took place via email on 4/25/08.

Informational e-mail sent to all providers 5/28/08 to communicate the use of the intra-facility and inter-facility transfer policy. This will also be communicated at the June monthly medical staff meeting.

Chart reviews will be conducted to ensure compliance over the next two months. The data will be compiled by the patient transfer office and ED staff. 100% of all transfers out of the facility will be reviewed. Random chart audits will be conducted for internal reviews with a total number of 30 charts over the two-month period. We expect 90% or better compliance with completing templated transfer note.

OIG Contact and Staff Acknowledgments

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