Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-01446-93

Combined Assessment Program Review of the Tennessee Valley Healthcare System Nashville, Tennessee

March 10, 2009

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 August 11–15, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Tennessee Valley Healthcare System (the system), Nashville, TN. 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 158 system employees. The system is part of Veterans Integrated Service Network (VISN) 9.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in three of the activities reviewed; one was a repeat recommendation from our previous CAP review. For these activities, the system needed to:

- Complete a comprehensive review of the QM Department to redesign the processes used to capture, trend, analyze, document, correct, and follow up required QM activities.
- Ensure that competency folders for emergency department (ED) registered nurses (RNs) are updated.
- Ensure consistent documentation of pain medication effectiveness within required timeframes.

The system complied with selected standards in the following five activities:

- Coordination of Care.
- Environment of Care (EOC).
- Pharmacy Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided 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 system is a tertiary, integrated health care system comprised of medical centers located in Nashville (NV) and Murfreesboro (MU), TN. It provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at nine community based outpatient clinics (CBOCs) in Arnold Air Force Base, Chattanooga, Clarksville, Cookeville, Dover, and Nashville (two CBOCs), TN, and in Fort Campbell and Bowling Green, KY. The system is part of VISN 9 and serves a veteran population of about 560,000 throughout middle Tennessee and southern Kentucky.

Programs. The system provides ambulatory, medical, surgical, and transplant services; spinal cord injury outpatient care; and a full range of extended care and mental health services. The NV campus is the only VA facility that supports all solid organ transplant programs, including kidney and bone marrow transplants. The MU campus is a VISN referral center for mental health, geriatrics, and extended care services. The system has 256 hospital beds and 245 community living center (CLC)[1] beds.

Affiliations and Research. The system is affiliated with Meharry Medical College and Vanderbilt University's School of Medicine and provides instruction for 806 trainees, including surgery and medical residents, dental students, and allied health students. In fiscal year (FY) 2007, the system research program had 254 projects and a budget of $18.1 million. (FY 2008 data was not available at the time of our review.) Important areas of research include cancer, diabetes, and post-traumatic stress disorder.

Resources. In FY 2007, medical care expenditures totaled $372 million. FY 2007 staffing was 2,938 full-time employee equivalents (FTE), including 245 physician and 649 nursing FTE. (FY 2008 data was not available at the time of our review.)

Workload. In FY 2007, the system treated 86,514 unique patients and provided 67,822 inpatient days in the hospital and 67,767 inpatient days in the CLC. The inpatient care workload totaled 919 discharges, and the average daily

[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.

census, including CLC patients, was 371.5. Outpatient workload totaled 656,276 visits. (FY 2008 data was not available at the time of our review.)

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 eight activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Pharmacy Operations.
- QM.
- SHEP.
- Staffing.

The review covered system operations for FY 2007 and FY 2008 through August 15, 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 system (*Combined*

Assessment Program Review of the VA Tennessee Valley Healthcare System, Nashville, Tennessee, Report No. 05-02298-65, January 30, 2006). The system had not corrected all findings related to trending and analysis of performance improvement (PI) data identified in our previous CAP review (see page 5).

During this review, we also presented fraud and integrity awareness briefings to 158 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 findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine if the system (a) had a comprehensive and effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) complied with Veterans Health Administration (VHA) directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers, QM staff, and other knowledgeable staff. In addition, we reviewed the QM self-assessment regarding compliance with QM requirements as well as committee minutes and other relevant QM documents. We also followed up on recommendations made in the previous CAP report to determine the effectiveness of corrective actions.

We found that the QM program did not provide the necessary monitoring and oversight to assure that some patient care processes were safe and effective, and as a result, opportunities for improvement may not have been identified and addressed. While we found that credentialing and privileging, patient safety, National Patient Safety Goals, operative and other invasive procedures, and patient complaints were monitored appropriately, we determined that eight additional areas were not monitored in accordance

with policy. A ninth area, utilization management, had not been monitored adequately in the past; however, monitoring recently improved. Therefore, we did not include this area in our list of deficiencies.

Overall, we found limited structure and accountability in relation to quality monitoring and PI efforts in the eight program areas. The deficiencies generally fell into one of the following categories:

Completeness of Quality Management Program Monitors. QM program monitors need to include specific elements to evaluate QM activities. Accreditation standards, VHA policies,[2] and local policies require monitoring of QM activities to identify trends and patterns resulting in improvement initiatives.

Documentation of Corrective Actions and Follow-Up. Identified QM improvement initiatives require documentation of corrective actions and follow-up plans. Accreditation standards, VHA policies,[3] and local policies define the processes and systems necessary to document planned corrective actions and follow-up to ensure that actions taken are effective.

Reporting to and/or Evaluation by an Oversight Committee. Accreditation standards, VHA policies,[4] and local policies require routine evaluation of important QM monitors by an oversight committee to ensure that improvement opportunities are evaluated and that appropriate actions are implemented.

Trending and Analysis of Data. Accreditation standards, VHA policies,[5] and local policies provide guidance on PI data trending and analysis expectations. Trending and analysis are necessary to identify improvement opportunities by evaluating the significance of the trends and analyzing the data.

[2] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005; VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006; VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008; and VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[3] Ibid.
[4] Ibid.
[5] Ibid.

This was a repeat finding from our previous CAP review. In that review, we found that although the system collected PI data, it was not consistently trended and analyzed. The system reported that they would develop a method for trending and analyzing PI data to correct the condition. However, during this review we found that the PI issues identified in our previous CAP review continued to exist.

The table below illustrates the extent to which the various types of deficiencies spanned multiple QM program areas.

QM MONITOR AREA	Incomplete QM monitors (not all required elements present)	Inadequate actions and follow-up	Inadequate reporting to and/or evaluation by an oversight committee	Inadequate data trending and analysis
Mortality Review and Analysis	X		X	
Medical Records Review	X	X		X
System Redesign/Patient Flow	X			
Peer Review		X	X	X
Adverse Event Disclosure		X		
Blood and Blood Products Review			X	X
Moderate Sedation				X
Restraint and Seclusion			X	X

We believe that redesign of the basic program monitoring structure for QM is needed to promote communication and information sharing and to comply with VHA and external accreditation standards. This action would likely improve the deficiencies we found in the individual program monitoring areas.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that QM experts complete a comprehensive review of the QM Department to redesign the processes used to capture, trend, analyze, document, correct, and follow up required QM activities.

The VISN and System Directors concurred with the findings and recommendation. A comprehensive review of the committee organizational structure, including a review of QM components, is in progress. This review is expected to result

in improved QM committee structure and quality monitoring activities. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purposes of this review were to evaluate the cleanliness and safety of the system's EDs and to determine compliance with VHA guidelines related to hours of operation, clinic capability (including management of patients with acute mental health diagnoses and patients transferred to other facilities), and staff competency. We evaluated ED EOC, and we interviewed ED directors and nurse managers.

The system has an ED located at each campus. Both are open the required 24 hours per day, 7 days per week. We found that the ED services provided were within the system's capability. In addition, we found that the system was in the process of drafting a diversion policy to manage patients transferred to other facilities. In the interim, system staff reported that they follow admission policies and do not divert patients to other hospitals.

We found that local policy did not address the procedure to follow if an ED employee failed a required competency. System staff reported that there are plans to amend the policy to include this component. While there had not been any instances of staff failing a required unit-based competency, nursing managers were able to verbalize procedures to follow if this occurred. Therefore, we did not make a recommendation in this area. We identified one area that needed improvement.

Emergency Department Registered Nurse Competencies. We reviewed competency folders for three ED RNs at each campus and found that three NV folders did not contain evidence of annual position-specific competencies, as required by local policy. In addition, we found that one MU folder contained an expired Advanced Cardiac Life Support certification, which was out of compliance with local policy.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that all ED RN competency folders be updated and maintained in accordance with local policy.

The VISN and System Directors concurred with the findings and recommendation. The system has reviewed and updated all ED RN competency folders and documented the plan to maintain the folders, including competency

verification forms, in accordance with local policy. The improvement plans are 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 the inpatient medical, surgical, intensive care, mental health, and transitional care units at the NV and MU campuses. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and ensured correct identification of patients prior to medication administration. We identified one area that needed improvement.

Documentation of Pain Medication Effectiveness. We found that on the units we reviewed, nurses did not consistently document the effectiveness of PRN (as needed) pain medications, as required by local policy. We assessed the Bar Code Medication Administration records for 32 patients hospitalized at the time of our visit. From August 4–11, 2008, nurses administered 272 doses of PRN pain medications to these patients. However, they did not document the effectiveness of 130 (48 percent) of the 272 doses within 4 hours, as required by local policy. (The longest time span from administration to documentation of effectiveness exceeded 3 days.) Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires consistent documentation of pain medication effectiveness within the required timeframe.

The VISN and System Directors concurred with the finding and recommendation. The system has implemented an action plan, which includes daily tracking of reports on PRN medication effectiveness and individual performance monitoring by nurse managers. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility transfers, and discharges were coordinated appropriately and met VHA and external accreditation standards. Coordinated consultations, transfers, and discharges are essential to optimal patient outcomes.

We reviewed 12 inpatient consultations, 12 intra-facility transfers, and 12 discharges. In general, we found timely consultative services, appropriate nursing and physician transfer notes, consistency between discharge orders and discharge summaries, and sufficient documentation of patient discharge instruction education. We made no recommendations.

Environment of Care

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

At the MU campus, we inspected the mental health, CLC, intensive care, and transitional care units and the dental clinic. At the NV campus, we inspected the acute care, mental health, dialysis, and intensive care units; the gastroenterology lab; four primary care clinics; the substance abuse outpatient clinic; and the dental clinic. We found that the system was generally clean and well maintained. The infection control program monitored exposures and reported data to clinicians to improve performance.

During our EOC tours, we identified several conditions requiring management attention. The following are the issues we identified and the actions taken while we were onsite.

- We found that 6 (20 percent) of the 30 medication and nourishment refrigerators required cleaning. All six refrigerators were cleaned, and staff verbalized the plan to monitor the refrigerators to ensure future cleanliness.

- We found a telephone with exposed electrical wires in a mental health unit staff break room. The telephone was removed.
- We found unsecured portable oxygen tanks. The oxygen tanks were temporarily secured, and a replacement holding rack was ordered.
- We found long blade scissors on a medication cart during a medication pass on the locked mental health unit. The inspector voiced her concern that these could be dangerous to the unit's patient population. In response, the scissors were replaced with a safer alternative.

In addition, at the NV campus, we found 13 corrugated cardboard boxes in the Nutrition and Food Service's food preparation and tray line areas. VHA policy addresses the need to keep corrugated cardboard to a minimum within the kitchen area to maintain pest and infection control. While we were onsite, managers removed the corrugated cardboard boxes and planned to identify alternative storage containers.

We also evaluated the status of deficiencies identified on the system's July 1, 2008, Mental Health Environment of Care Checklist. The checklist serves as a tool for documentation and tracking of identified environmental safety concerns. We found that, in general, the system had taken appropriate corrective actions. In cases where conditions could not be immediately corrected (for example, structural renovations were required), the system implemented Interim Life Safety Measures pending completion of permanent corrections. We made no recommendations.

Pharmacy Operations

The purposes of this review were to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances and to evaluate the safety and security of the inpatient and outpatient pharmacies' internal physical environments. We also assessed whether clinical managers had processes in place to monitor patients for polypharmacy.

We assessed whether the system's policies and practices were consistent with VHA regulations governing pharmacy and controlled substances security. We inspected inpatient and outpatient pharmacies for security, EOC, and infection

control, and we interviewed appropriate Pharmacy Service and Police and Security Service personnel.

Pharmacy Controls. Our review showed that the system had appropriate policies and procedures to ensure the security of controlled substances and to ensure the safety and security of the pharmacies' internal physical environments. The system's Controlled Substances Coordinator (CSC) implemented actions when necessary, and training records showed that the CSC and controlled substances inspectors received appropriate training to execute their duties. Any identified discrepancies had been followed up in accordance with VHA policy. We also found that managers reported all controlled substances diversions or suspected diversions to the OIG. The pharmacies were secure, clean, and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and control disease states; however, excessive use of medications can result in adverse reactions and increased risk 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.

We found that managers had developed effective processes and monitors 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.

Staffing

The purpose of this review was to evaluate whether the system had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the system had developed adequate staffing guidelines using hours per patient day and hours per shift.

We reviewed actual staffing for 22 inpatient units, the two EDs, and four specialty areas. We found that the system's approved guidelines for nurse staffing were generally met in all areas reviewed. In addition, we found that specific

actions had been taken to ensure safe patient care, including the use of contract licensed practical nurses and nursing assistants. We made no recommendations.

Survey of Healthcare Experiences of Patients

SHEP is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients.

VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming. The purpose of this review was to assess the extent that VHA facilities used SHEP data to improve patient care, treatment, and services.

The graphs on the next page show the system's performance in relation to national and VISN performance. Figure 1 shows the system's SHEP performance measure results for inpatients, and Figure 2 shows the system's SHEP performance measure results for outpatients.

Figure 1:

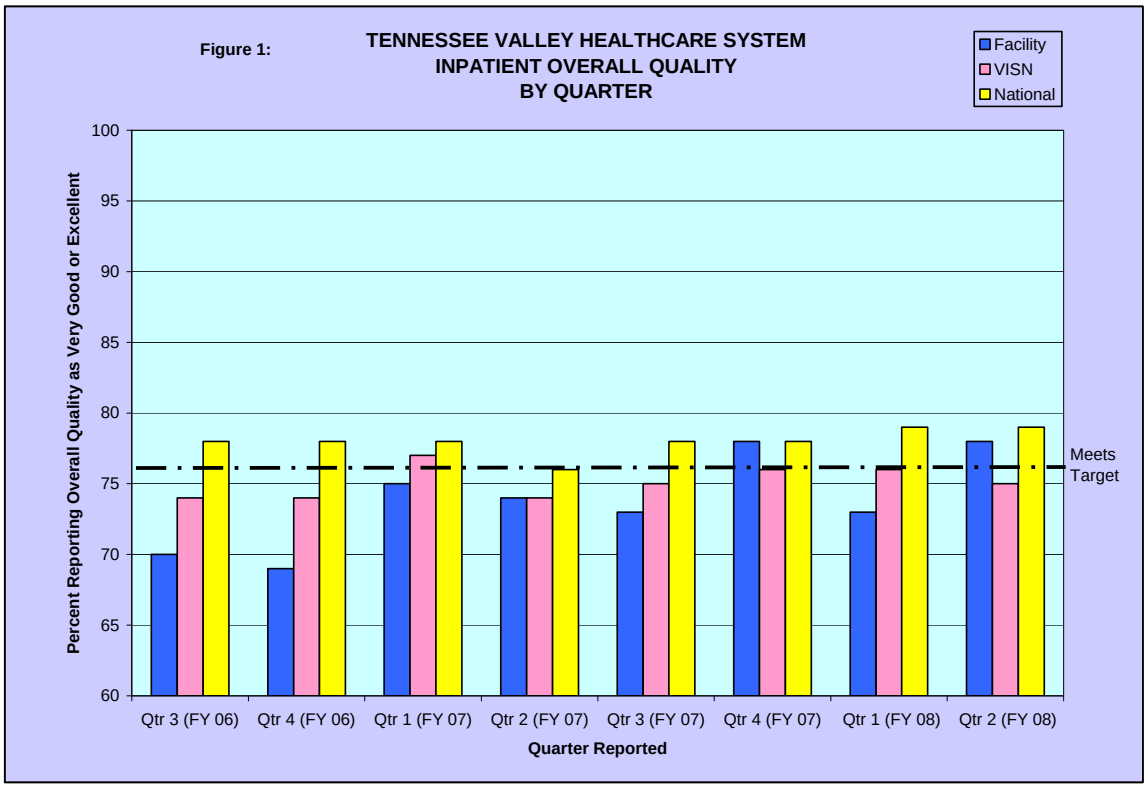
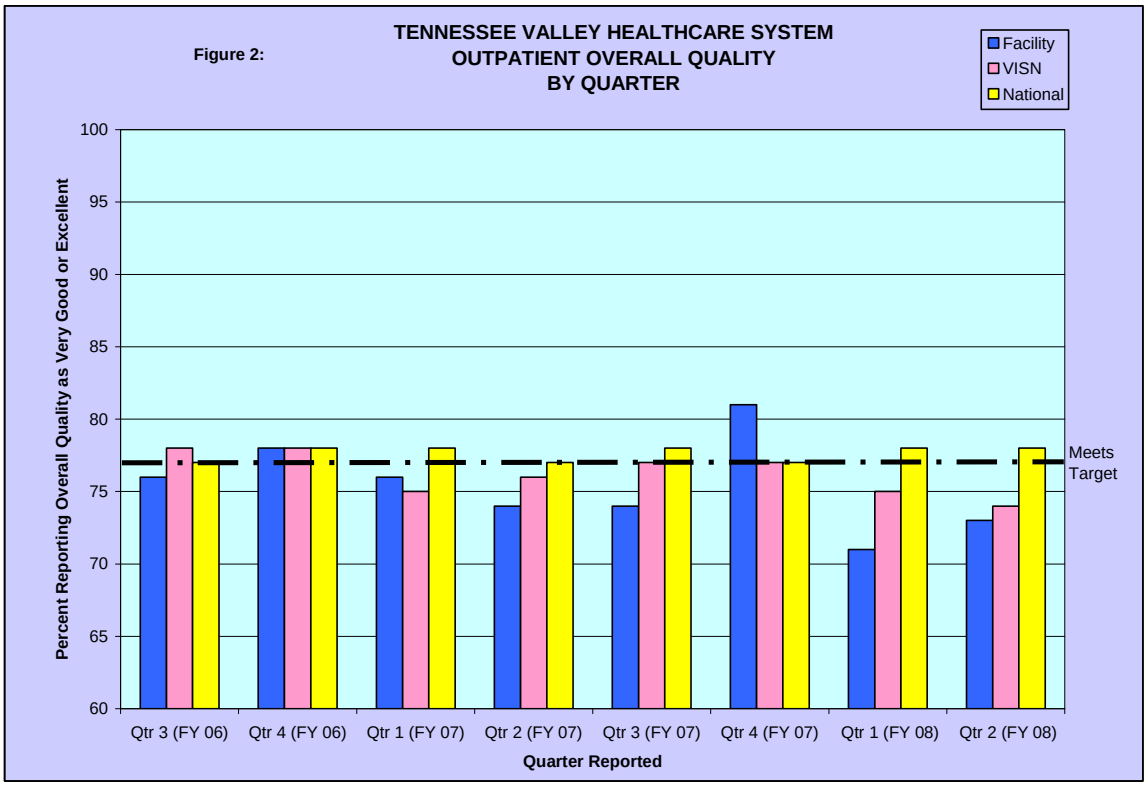


Figure 2:



The system's inpatient and outpatient overall SHEP scores for the 3rd quarter of FY 2006 through the 2nd quarter of FY 2008 did not meet established targets for 6 of the 8 quarters. We were told that previous program managers had not aggressively managed the SHEP program.

At the time of our visit, we found that the system's multidisciplinary Veteran Satisfaction Improvement Committee (VSIC) adequately analyzed and reported SHEP survey results and addressed deficiencies. New SHEP program managers educated service chiefs on service-specific patient satisfaction issues and required service chiefs to submit corrective action plans and follow up when indicated. In addition, the VSIC was working to improve patient satisfaction through enhanced telephone services, expansion of offsite clinic access, staff education regarding patient satisfaction issues, and deployment of customer service "ambassadors" to patient care areas. The system continues to review the effectiveness of its actions and make modifications as needed. Since internal satisfaction scores have shown improvement, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 23, 2009

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Pamela Kelly, Staff Assistant to the Network Director, at 615-695-2205 or me at 615-695-2206.

(original signed by:)

John Dandridge, Jr.

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 20, 2009

From: Director, Tennessee Valley Healthcare System (626/00)

Subject: **Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee**

To: Director, VA Mid South Healthcare Network (10N9)

Director, Management Review Service (10B5)

1. On behalf of the Tennessee Valley Healthcare System, Nashville, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report. We had already been actively working to improve or enhance several of these areas and welcome the "fresh eyes" perspective provided by this report.

2. Included herein is an outline of improvement actions already taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes in healthcare system.

(original signed by:)

Juan Morales, RN

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 System Director requires that QM experts complete a comprehensive review of the QM Department to redesign the processes used to capture, trend, analyze, document, correct, and follow up required QM activities.

CONCUR

TVHS Response: A retired Quality Manager expert who is under contract has completed a comprehensive review of the committee organizational structure, including a review of many of the QM components identified by the Combined Assess Program (CAP) review.

For each organizational committee, this individual is researching VHA, VA, VISN, and TVHS references. She then composes memos to the chairperson of each committee detailing inconsistencies with current practice and required processes including:

1. Composition of membership

2. Attendance rates

3. Quality monitoring activities

4. Documentation requirements including:

    - collection of data
    - trending of data
    - analysis of data
    - utilization of data to effect improvements
    - evidence of corrective actions
    - follow-up plans
    - reporting timeframes to the oversight committee

Sample agendas and reporting schedules for each required element are developed. Instructions are provided for the expected "Reporting Format" for quality monitoring activities to include the use of charts to better

ascertain progress toward goals. Minutes of all committees will be monitored periodically to assure that all requirements are accomplished.

TVHS policy, Committee Minutes: Preparation, Submission and Distribution, was approved by the Governing Council on February 11, 2009. This policy details the documentation and reporting expectations.

Memos as described above have been completed for 16 committees, including the following QM monitor areas identified in the table on page 5 of the report:

1. Medical Records Review
2. System Redesign/Patient Flow (Quality Executive Board)
3. Moderate Sedation
4. Restraint and Seclusion (Quality Executive Board)
5. Memo will be completed for Blood and Blood Products Review (Tissue and Transfusion Committee) by February 27, 2009.

A review of Peer Review was conducted in conjunction with a review of the Risk Manager work processes. Consultation and advice relating to follow-up, trending, and analysis of data were provided to the Risk Manger who manages this program by the Interim Quality Manager and the contract individual. Reporting timeframes to the oversight committee (Clinical Management Board) have been established.

Reporting time frames to the oversight committee (Clinical Management Board) have been established for Mortality Review and Analysis. References will be evaluated by February 27 to ensure all required elements are being addressed.

Restraint and Seclusion reporting has been established to the oversight committee (Quality Executive Board). Instructions for trending and analysis of data have been provided to the Chief Nurse who collects the data.

Follow-up responsibility for each of these areas will be assigned to QM specialists for tracking, analysis, and recommendations as appropriate.

Recommendation 2. We recommended that the VISN Director ensure that the System Director require that all ED RN competency folders be updated and maintained in accordance with local policy.

CONCUR

TVHS Response: TVHS has completed review of all Emergency Department competency folders which have been updated and will be

maintained in accordance with system policy. Competency verification forms have been updated according to revised TVHS policy.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires consistent documentation of pain medication effectiveness within the required timeframe.

CONCUR

TVHS Response: Following CAP review, the following action plan has been implemented: (1) Daily tracking and monitoring of reports from BCMA Coordinators on PRN effectiveness; (2) Staff are receiving training on BCMA documentation of PRN effectiveness. Target date for completion 3/15/09; (3) Since CAP visit, TVHS compliance is being monitored and tracked by Nursing Service daily. Follow-up to appropriate Nurse Managers regarding individual performance or compliance is ongoing daily; (4) Noon clinical huddle has been active; however, since December, the topic of PRN effectiveness has been added and is discussed daily. There is a project leader identified that disseminates information and recommendations from the clinical huddle to improve performance for PRN effectiveness; (5) Nursing service reviewed list of PRN medications and revised the list based on appropriate effectiveness within the 4 hour timeframe.

OIG Contact and Staff Acknowledgments

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