Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02561-75

Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts

February 24, 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 December 8–12, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Edith Nourse Rogers Memorial Veterans Hospital (the hospital), Bedford, MA. 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 for 63 hospital employees. The hospital is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

This CAP review covered eight operational activities. We also followed up on two review areas from the June 2005 CAP review. We identified the following organizational strengths and reported accomplishments:

- Improved colonoscopy timeliness.
- Transitional beds for homeless veterans.
- Computerized police response system.

We made recommendations in five of the activities reviewed. For these activities, hospital managers needed to:

- Ensure that clinical data are consistently trended and analyzed.
- Develop processes to ensure that action items identified through the root cause analysis (RCA) process are implemented and monitored and that the status of implementation is reported.
- Ensure that clinical managers implement The Joint Commission's (JC) national patient safety goal (NPSG) for anticoagulation therapy.
- Ensure the documentation of pain medication effectiveness within the required timeframe.
- Develop a standardized procedure for medication administration for patients in isolation.
- Ensure that nurses document patient transfer notes in accordance with hospital policy.
- Ensure that patient discharge orders are documented in the medical record prior to patients being discharged.

- Ensure that medication refrigerator temperatures are monitored daily and that controlled substances (CS) stored in medication refrigerators are secured.
- Ensure that suicide prevention information is available in all patient care areas.
- Ensure that discharged urgent care (UC) clinic patients receive written instructions.

The hospital complied with selected standards in the following three activities:

- Pharmacy Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Katherine Owens, Director, Bedford Office of Healthcare Inspections.

Comments

The VISN and Hospital Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–20 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 hospital is located in Bedford, MA, and provides long-term care and mental health (MH) services. It also provides primary care services at four community based outpatient clinics in Fitchburg, Gloucester, Haverhill, and Lynn, MA. The hospital is part of VISN 1 and serves a veteran population of more than 450,000[1] in the East Market.[2]

Programs. The hospital provides comprehensive health care through primary care, long-term care, residential care, and inpatient and outpatient MH services.

Affiliations and Research. The hospital is affiliated with Boston University's School of Medicine, the University of Massachusetts' Medical School, and Harvard School of Dental Medicine. Forty-eight residents rotated through the hospital during the last academic year. The hospital also provides training in nursing and other health care professions, such as psychology, pharmacy, social work, and physical and occupational therapy.

The hospital is a VA Health Services Research and Development Center of Excellence focused on health quality assessment, health outcomes measurement, and health economics. It has a research budget of more than $5 million, and the research program has approximately 165 projects and 66 investigators.

Resources. In fiscal year (FY) 2008, the hospital's medical care budget totaled approximately $139 million. FY 2008 staffing was 1,154 full-time employee equivalents (FTE), including 45 physician and 383 nursing FTE.

Workload. In FY 2008, the hospital treated approximately 17,500 unique patients and provided inpatient care to more than 1,700 patients. It had 117 operating hospital beds with an average daily census (ADC) of 89 and 304 operating community living center (CLC)[3] beds with an ADC of 241. Outpatient workload totaled over 175,000 visits.

[1] The hospital is a referral center for the VA Boston Healthcare System in Massachusetts and the Providence VA Medical Center in Rhode Island, which accounts for the large number of veterans served.
[2] Geographically, the East Market includes all Massachusetts counties east of Worchester and the entire state of Rhode Island.
[3] 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 eight activities:

- Coordination of Care.
- Emergency/UC (E/UC) Operations.
- Environment of Care (EOC).
- Medication Management.
- Pharmacy Operations.
- QM Program.
- SHEP.
- Staffing.

The review covered hospital operations for FY 2008 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from the prior CAP review of the hospital (*Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts,* Report No.05-01508-114, March 27, 2006). In that report, we identified improvement opportunities in radiology

timeliness and EOC. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the identified deficiencies, and we consider those issues closed.

During this review, we provided fraud and integrity awareness training for 63 employees. The training 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 made 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.

Organizational Strengths

Improved Colonoscopy Timeliness

In August 2006, the hospital arranged to have colonoscopy procedures performed at a community hospital in an effort to ensure timely patient care. Currently, four community hospitals are utilized for this service. As a result, the time for a patient to have a colonoscopy performed improved from 159 days in March 2007 to 19 days in November 2008. The hospital continues to monitor timeliness to ensure that improvement is sustained over time.

Transitional Beds for Homeless Veterans

In July 2007, the hospital developed a transitional bed program to ensure that homeless patients waiting for admission to the substance use disorder (SUD) treatment program had safe and supervised transitional housing. Prior to implementation of the program, patients who had no permanent housing either remained on the acute inpatient psychiatry unit, which was costly, or were discharged to homeless shelters until a hospital lodging bed became available. The hospital now temporarily houses the patients in community residential care beds. Since the inception of the program, the hospital has reported a cost avoidance of approximately $683,000 and a decrease in the number of patients lost to SUD treatment.

Computerized Police Response System

The hospital implemented a computerized police response system. The Lynx system is a computer desktop based system that uses the information technology network to transmit panic alarms to a central receiving location in the

Police Service Dispatch Center. The system is activated by a designated "hotkey" combination that identifies the exact location of the desktop from which the alarm was sent and triggers a police response.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the hospital had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The hospital's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified two areas that needed improvement.

Data Analysis. The hospital collected appropriate data; however, a sample review of data and committee minutes showed that in-depth analysis of data was frequently lacking and that data were not consistently trended over time. Consequently, evidence regarding how managers used data to identify improvement opportunities was limited.

Patient Safety. Veterans Health Administration (VHA) regulations[4] require that health care organizations ensure that action items identified through the RCA process are implemented and monitored for efficacy. We found that RCAs were generally thorough; however, it was difficult to track actions to closure and to determine how managers monitored the effectiveness of actions. The hospital needed to develop processes to ensure that responsible managers implement and monitor corrective actions and report the status of those actions until they are closed.

Additionally, managers did not have a plan to implement the NPSG to reduce potential patient harm associated with anticoagulation therapy. Although hospital managers had designated responsibility for the development and

[4] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

implementation of the plan, at the time of our review, this had not been fully accomplished.

Recommendation 1 We recommended that the VISN Director ensure that the Hospital Director requires that clinical data are consistently trended over time and analyzed to identify improvement opportunities.

Recommendation 2 We recommended that the VISN Director ensure that the Hospital Director requires the development of effective processes to ensure that RCA action items are implemented and monitored and that the status of implementation is reported to an appropriate committee.

Recommendation 3 We recommended that the VISN Director ensure that the Hospital Director requires that managers fully implement the NPSG for anticoagulation therapy.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that training on concepts of data management, analysis, and trending will be provided to responsible staff and that senior managers are actively recruiting for a data analyst to support staff in the use of data management tools. Managers will be required to report RCA action item progress to the QM Board, which will review RCAs during monthly meetings. They also reported that clinical managers have developed a plan to ensure the implementation of the NPSG for anticoagulation therapy. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA health care facilities had adequate medication management processes to ensure safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes on inpatient and CLC units, and we interviewed nurse managers and other nursing staff. Additionally, we observed nurses administering medications, and we asked patients if nurses scanned their wristbands prior to administering their medications.

We found adequate management of medications brought into the facility by patients or their families. Additionally, we found that the processes for reconciling CS discrepancies at the unit level were adequate. However, we identified two areas that needed improvement.

Pain Medication Effectiveness. VHA regulations[5] require that clinicians monitor PRN[6] pain medications for effectiveness. Additionally, the hospital's policy governing PRN pain medications requires that effectiveness assessments occur within 4 hours after administration. We reviewed 428 administered doses of PRN pain medications and found that effectiveness assessments were not documented within the required timeframe for 184 (43 percent) of the doses.

Medication Administration. The hospital's policy governing medication administration requires nurses to scan patients' wristbands before administering medications. Scanning wristbands correctly identifies patients and reduces medication errors. However, this can be challenging when patients require isolation because equipment taken into an isolation room can become contaminated during the scanning process. Neither the hospital's medication administration policy nor infection control (IC) policies addressed procedures for the use of scanning equipment on isolated patients. We asked nurse managers and staff nurses about the procedures used, and we received varying answers. A standardized procedure would ensure that isolated patients have their wristbands scanned consistently and that equipment is properly protected to reduce the vulnerability of the spread of infections.

Recommendation 4 We recommended that the VISN Director ensure that the Hospital Director requires the documentation of PRN pain medication effectiveness within the required timeframe.

Recommendation 5 We recommended that the VISN Director ensure that the Hospital Director requires the development of a standardized medication administration procedure for patients in isolation.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that nurse managers will monitor the status of documentation of PRN pain medication effectiveness weekly. They also reported that IC and clinical applications managers will develop procedures for administration of medications to patients in isolation and for the protection of BCMA equipment used to scan their wristbands. The implementation plans are acceptable, and

[5] VHA Directive 2003-021, *Pain Management*, May 2, 2003.
[6] PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as the circumstances require.

we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether VHA health care facilities had adequate processes to ensure coordination of care across the continuum of patient services. We reviewed three aspects of patient care: (a) consults, (b) intra-facility transfers, and (c) discharges. We found that providers managed patients' consults appropriately. However, we identified two areas that needed improvement.

Intra-Facility Transfers. The hospital's policy governing patient transfers requires that nurses complete documentation that contains specific patient information prior to transfer. We reviewed medical record documentation for six patients transferred within the hospital and found deficiencies in five records. Two records had no transfer notes. The other three records did not contain all the elements required by the hospital's policy.

Patient Discharges. We reviewed medical record documentation for 12 patients discharged from inpatient units and found that 3 (25 percent) medical records showed that physicians wrote discharge orders 1 to 3 weeks after the date of discharge. Consequently, these three patients left the hospital without appropriate documentation that they had been discharged. VHA regulations require that patients be discharged only by the order of a physician.[7]

Recommendation 6 We recommended that the VISN Director ensure that the Hospital Director requires that nurses document patient transfer notes in accordance with hospital policy.

Recommendation 7 We recommended that the VISN Director ensure that the Hospital Director requires that patient discharge orders are documented in the medical record prior to patients being discharged.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that managers will develop a patient transfer template to ensure documentation of all required information prior to patient transfer. Nurses will be trained on the use of the template. They further reported that senior clinical managers are developing

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

processes to ensure that discharge orders are documented in medical records prior to patient discharges and that the Medical Record Review Committee will monitor for compliance. The implementation plans 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 whether the hospital complied with selected IC standards and maintained a clean, safe, and secure environment. VHA facilities are required to establish comprehensive EOC programs that fully meet VA, Occupational Safety and Health Administration, and JC accreditation standards.

We inspected the following areas: (a) three psychiatry units, including the acute psychiatry unit; (b) the geriatric evaluation and management unit; (c) two CLC units; (d) three geriatric research and education clinical centers; (e) the dental clinic; and (f) the inpatient and outpatient pharmacies. The areas we inspected were clean and well maintained, and managers expressed satisfaction with the housekeeping staff assigned to their areas. Also, we evaluated the IC program's management of data and processes in which the data were used to improve performance and found the program satisfactory.

Additionally, we reviewed the acute psychiatry unit to determine if managers identified environmental hazards that potentially posed threats to patients and to ensure that staff received specialized training. The hospital provided documentation of risk assessment and abatement tracking of safety issues previously identified on the unit, and we found that suicide risk training was completed. However, we identified two areas that needed improvement.

Safety. We found that temperature logs for two medication refrigerators were not monitored in accordance with the hospital's policy governing refrigerator temperature monitoring. Documentation of daily temperature monitoring was lacking from the temperature logs for the medication refrigerator on one CLC unit and for one of the refrigerators in the inpatient pharmacy. Appropriate temperature controls ensure medication safety and maintenance of medication efficacy. Additionally, we found that a nursing unit medication refrigerator containing CS was unlocked and unattended.

Suicide Prevention Information. We found that suicide prevention materials were not posted in highly visible areas throughout the hospital, as required.[8] We noted that while some suicide prevention posters were in place, many provided just a website as contact information and lacked the suicide hotline phone number. Also, many high-traffic patient areas, such as pharmacy, primary care, optometry, and cardiology waiting rooms, lacked information. The dental clinic waiting room was the only location where pamphlets were available.

Recommendation 8 We recommended that the VISN Director ensure that the Hospital Director requires that medication refrigerator temperatures are monitored daily and that CS stored in medication refrigerators are secured.

Recommendation 9 We recommended that the VISN Director ensure that the Hospital Director requires that suicide prevention information is available in all patient care areas.

The VISN and Hospital Directors agreed with the findings and recommendations. They reported that managers developed processes for daily monitoring of medication refrigerator temperatures and for security of CS stored in the medication refrigerators. They also reported that suicide prevention information is now available in all areas of the hospital. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purposes of this review were to evaluate selected aspects of E/UC clinical services, consults, staffing, and staff competencies. We also evaluated whether the physical environment was clean and safe and whether managers maintained equipment appropriately.

The hospital did not have an emergency department but operated a UC clinic during administrative hours. We interviewed clinic managers, staff members, and staff specifically involved in the transfer of clinic patients to other facilities. We reviewed policies and other pertinent documents, including equipment maintenance records. We also reviewed medical records of patients who were admitted

[8] Deputy Under Secretary for Health for Operations and Management, memorandum to VISN and facility Directors, December 7, 2007.

to the hospital, discharged, or transferred to other medical facilities.

Our review showed that consults and staffing were appropriate. We conducted an EOC tour and found that the area was clean and safe and that equipment was appropriately maintained. However, we identified one area that needed improvement.

Written Discharge Instructions. JC accreditation standards require that written discharge instructions be provided to patients when they are discharged from an ambulatory care facility. We reviewed the medical records of 11 patients discharged from the UC clinic and found no documentation to support that the patients received written instructions.

Recommendation 10

We recommended that the VISN Director ensure that the Hospital Director requires that UC clinic patients receive written discharge instructions.

The VISN and Hospital Directors agreed with the finding and recommendation. They reported that clinical managers have developed processes to ensure that UC clinic patients receive discharge instructions and that the Medical Record Review Committee will monitor for compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Pharmacy Operations

The purposes of this review were to evaluate whether VHA health care facilities had adequate controls to ensure the security and proper management of CS and pharmacies' internal physical environments and whether clinical managers had processes to monitor inpatient and outpatient medication use to avoid polypharmacy in vulnerable populations, such as the elderly and MH patients.

Pharmacy Controls. We reviewed VHA regulations[9] governing pharmacy and CS security, and we assessed whether the hospital's policies and processes were consistent with VHA regulations. We reviewed the CS inspection program and inspected inpatient and outpatient

[9] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

pharmacies for security, EOC, and IC issues. In addition, we interviewed the CS Coordinator, and appropriate Pharmacy Service managers. The hospital's CS inspection program was organized and well managed.

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.[10] Some literature suggests that elderly patients and MH patients are among the most vulnerable populations for polypharmacy.[11]

We interviewed pharmacy clinical managers to determine the hospital's efforts to monitor and avoid inappropriate polypharmacy. Clinical pharmacists identified patients who were prescribed multiple medications, reviewed the patients' medication regimens to avoid complications related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA health care facilities had developed comprehensive nurse staffing guidelines and whether the guidelines were followed. We reviewed nurse staffing documents for eight inpatient units, and we interviewed nurse managers. We found the staffing methodology to be appropriate. We made no recommendations.

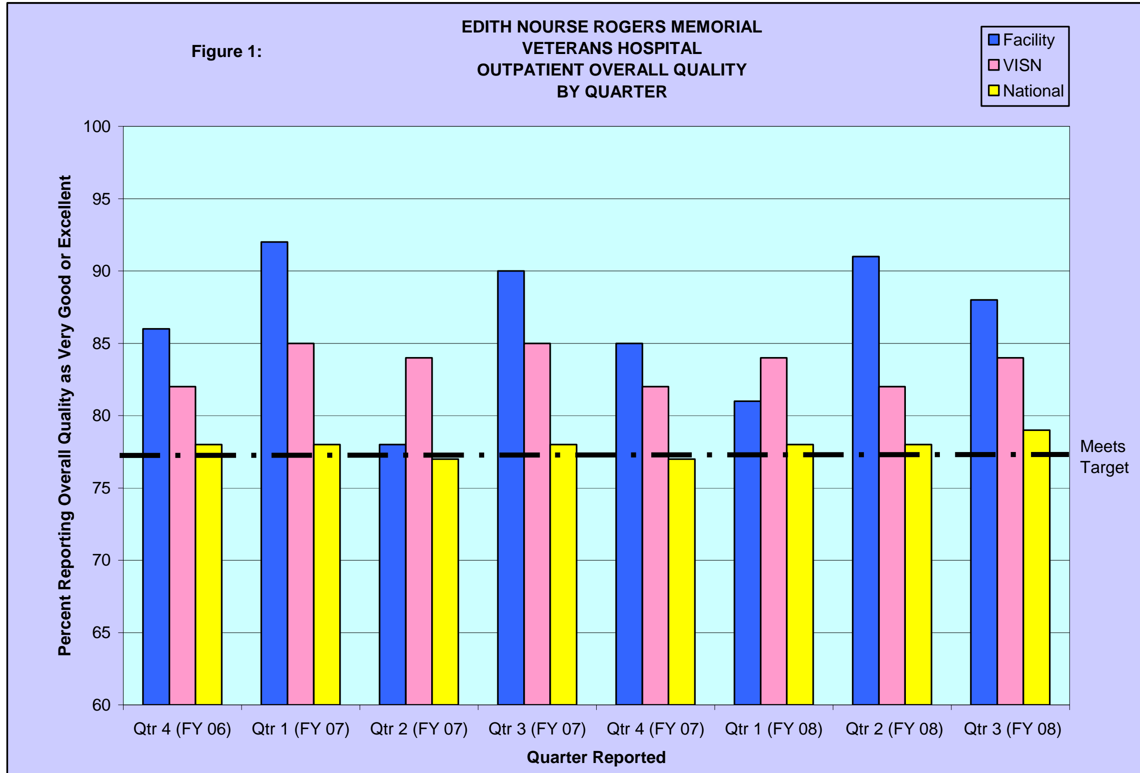
Survey of Healthcare Experiences of Patients

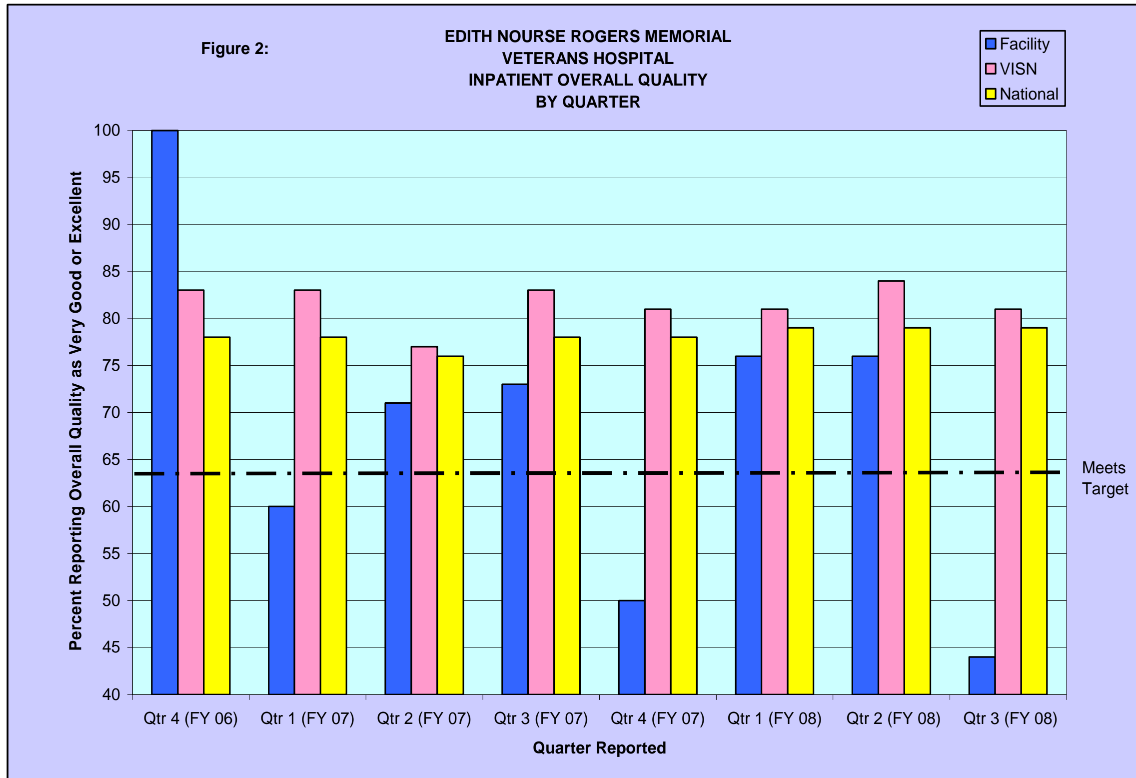
The purpose of this review was to assess the extent that VHA health care facilities use quarterly or semi-annual SHEP results to improve patient care and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical,

[10] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[11] 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.

methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percent for outpatients.

We reviewed SHEP scores for quarter 4 of FY 2006 through quarter 3 of FY 2008. Figures 1 and 2 below and on the next page show the hospital’s patient satisfaction performance measure results for outpatients and inpatients, respectively.





The outpatient scores were above target for all 8 quarters reviewed. The inpatient scores were above target for 5 of the 8 quarters reviewed. Managers analyzed SHEP data, developed improvement strategies, and monitored the results of the strategies. Survey results and improvement strategies were distributed throughout the organization. Therefore, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2009

From: Director, VA New England Healthcare System (10N1)

Subject: **Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

We concur with the recommendations and have actions listed below. Please contact VISN 1 Quality Management Officer (Allan Shirks, MD, 781-687-4850) if anything further is needed.

(original signed by:)

MICHAEL F. MAYO-SMITH, MD, MPH
Network Director

Hospital Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 30, 2009

From: Director, Edith Nourse Rogers Memorial Veterans Hospital (518/00)

Subject: **Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts**

To: Director Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

1. We have reviewed the OIG draft report and appreciate the opportunity to provide comments. After careful review, we have concurred with all recommendations and have provided the following implementation plan.

2. If you have any questions or need additional information, please contact Mr. Michael Carey, Quality Manager, at (781) 687-3080.

(original signed by:)

Tammy A. Follensbee

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 Hospital Director requires that clinical data are consistently trended over time and analyzed to identify improvement opportunities.

Concur

Plan: A gap analysis will be conducted to determine current strengths and opportunities with respect to data management and analysis skills. Responsible staff for data management, analysis, and trending within their respective service and/or hospital committee will receive additional training on concepts for managing, analyzing, and trending data over time. In addition, designated staff will receive training on performance improvement opportunities and the role of data. Further, staff will be trained in the proper documentation of staff/committee minutes to properly reflect data analysis and follow-up actions. We plan to assign one person on each major hospital committee with the responsibility for ensuring data is properly analyzed and trended and actions are followed through to appropriate resolution. Currently, the center memo which defines format for staff/committee minutes is being revised to facilitate a standardized approach to documenting minutes.

Bedford is actively recruiting a data analyst who will be instrumental in providing expertise and continued support for staff in the use of data management tools. The VISN education office has recently submitted a statement of work for a VISN wide educational program concerning "Collecting, Analyzing, Presenting Quality Data – Tips and Techniques for Getting Your Data Under Control," and we have projected sending ten staff to that program.

Target Date for Completion: June 1, 2009

Recommendation 2. We recommended that the VISN Director ensure that the Hospital Director requires the development of effective processes to ensure that RCA action items are implemented and monitored and that the status of implementation is reported to an appropriate committee.

Concur

Plan: The Patient Safety Manager maintains a log of all RCA approved recommendations and has coordinated with the Director's Office to ensure status of implementation is reported directly to the Quality Management Board (QMB). A memo from the Hospital Director has been sent to all managers on January 29, stressing the importance of ensuring full implementation of all recommendations identified in each RCA. This memo highlighted the process change and informed managers they would be reporting updates of RCA recommendations to the QMB until completion. A reporting structure was created for monthly QMB meetings to include RCA reviews.

Recommend this issue be closed.

Recommendation 3. We recommended that the VISN Director ensure that the Hospital Director requires that managers fully implement the NPSG for anticoagulation therapy.

Concur

Plan: This was discussed at our QMB January 21, 2009, and a task group consisting of the Associate Director/Patient Nursing Service, ACOS/Geriatrics & Extended Care, Chief, Pharmacy, and Patient Safety Manager was appointed to assess current status and those actions necessary to bring us into full compliance. On January 27, they had their first meeting and reviewed all requirements of the NPSG. As a result, the following plan has been developed:

- Expand the functions of existing Coumadin clinic to include, in addition to a pharmacist, a dietitian, Expanded Practice Nurse, and an administrative support person. **Target Date – March 1, 2009**

- Develop an anticoagulation management program to provide individualized care for all patients prescribed anticoagulation therapy. **Target Date – March 1, 2009**

- The anticoagulation team will review the records of all patients on Coumadin and will collaborate with the unit specific interdisciplinary team to assure proper coumadin dosing. **Target Date – March 1, 2009**

- Update existing Coumadin clinic policy to reflect above plan. **Target Date – March 1, 2009**

- Develop monitor to assess effectiveness of program. **Target Date – March 1, 2009**

- Monitoring for the first two months after implementation will be done by Quality Management and reported to the COS. Continued monitoring will be included into the functions of the P&T Committee.

Recommendation 4. We recommended that the VISN Director ensure that the Hospital Director requires the documentation of PRN pain medication effectiveness within the required timeframe.

Concur

Plan: A report to monitor PRN pain effectiveness will be run on a weekly basis and posted on a SharePoint site giving nurse managers and the nurse executive read only access. Nurse managers will monitor on a weekly basis, status of documenting the effectiveness of PRN medications and take corrective action as necessary. In addition, our local policy will be updated to require PRN effectiveness documentation within eight hours. This process will be monitored on a monthly basis with an expected rate of 90% completion and reported to the Clinical Services Performance Improvement Council (CSPIC) within 90 days of implementation.

Target Date for Completion – March 30, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Hospital Director requires the development of a standardized medication administration procedure for patients in isolation.

Concur

Plan: The Infection Prevention and Control Practitioner will coordinate with the Clinical Applications Coordinator to develop a policy and procedure for scanning of the wrist bands on CLC and Behavioral Health veterans who are on contact or droplet precautions. In addition, the policy will ensure the BCMA cart is protected and when necessary properly disinfected so to prevent the spread of infection.

Target Date for Completion – March 30, 2009

Recommendation 6. We recommended that the VISN Director ensure that the Hospital Director requires that nurses document patient transfer notes in accordance with hospital policy.

Concur

Plan: The Clinical Applications Coordinator will develop a patient transfer template that contains specific patient information. This template will be placed in the shared template folder of CPRS for use when transferring patients. **Target: February 28, 2009.** Nurses will be educated on the

use of the template by April 30, 2009. A monitor will be developed and results reported to the Clinical Services PIC for appropriate action.

Target Date for Completion – April 30, 2009

Recommendation 7. We recommended that the VISN Director ensure that the Hospital Director requires that patient discharge orders are documented in the medical record prior to patients being discharged.

Concur

Plan:

1. The Chief of Staff sent a memo to all physicians informing them of the need to document discharge orders in the medical record prior to the patient being discharged. **Completion Date: January 29, 2009**

2. Hospital Memoranda #11.14, Electronic Orders and #122.03, Discharge Planning, will be modified to require the responsible physician to document an order for discharge at the time of discharge and that the discharge will not occur without the written order. **Completion Date: March 30, 2009**

3. Health Information Management Service (HIMS) will develop a monitor for the timeliness of discharge orders. The results of the monitor will be incorporated into the Medical Records Review Committee review schedule commencing January 30, 2009, thru July 31, 2009. After the six month time period, based on the data, the committee will review the needed frequency for further monitoring.

Target Date for Completion: March 30, 2009

Recommendation 8. We recommended that the VISN Director ensure that the Hospital Director requires that medication refrigerator temperatures are monitored daily and that CS stored in medication refrigerators are secured.

Concur

Plan: The Associate Director/Patient Nursing Services assigned the monitoring of the refrigerator for temperatures and proper security to the night shift on each unit. Documentation of the monitoring is forwarded to the Nursing Administrative Coordinator who will forward this report to the Nurse Executive Group at morning report. In addition, nurse managers in out-patient settings and the Chief, Pharmacy Service, will send a daily E-Mail message to the Nursing Administrative Coordinator for inclusion in the reporting. This will be reviewed quarterly at the Clinical Services PIC.

Action complete: Recommend this issue be closed.

Recommendation 9. We recommended that the VISN Director ensure that the Hospital Director requires that suicide prevention information is available in all patient care areas.

Concur

Plan: Our Suicide Prevention Coordinator conducted a facility assessment to determine all areas that needed suicide prevention materials. She collaborated with Environmental Management Service (EMS) to ensure that current suicide prevention materials were made available in all areas and that current suicide prevention posters were hung in identified areas. She is finalizing a process to ensure that printed materials are routinely replenished and updated as needed.

Target Date for Completion – February 27th, 2009

Recommendation 10. We recommended that the VISN Director ensure that the Hospital Director requires that UC clinic patients receive written discharge instructions.

Concur

Plan: Specialty & Acute Care Line Manager communicated the above findings to all ambulatory care staff in a staff meeting on December 23, 2008, and an ad-hoc group met on December 30, 2008, and discussed the current discharge instruction sheets that were being used. They suggested and implemented modifications to the discharge instruction sheets. During the Urgent Care staff meeting on January 20, 2009, the urgent care providers were re-educated to document that the discharge instructions sheets are being handed out. A process change was implemented to have all discharge instruction sheets, needing to be filled out, placed on the urgent care desk thus prompting the urgent care providers to complete them and document that they were given to the patient. All Urgent Care physicians are currently using the paper discharge instructions and documenting this process in CPRS. The Medical Record Review Committee will be tasked with incorporating this monitoring into their scheduled medical record review process.

Target Date for completion – March 30, 2009

OIG Contact and Staff Acknowledgments

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