Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03043-70

Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, Texas

February 19, 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 1–5, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the West Texas VA Health Care System (the system), Big Spring, TX. 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 117 system employees. The system is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in five of the activities reviewed. For these activities, the system needed to:

- Complete root cause analyses (RCAs) within the 45-day timeframe.
- Review medical records at the point of care on an ongoing basis.
- Monitor the copy and paste function in the electronic medical record.
- Ensure that clinicians document pain medication effectiveness in a timely manner.
- Correct identified environment of care (EOC) deficiencies.
- Ensure that monthly controlled substances (CS) inspections are completed the day initiated, as required by Veterans Health Administration (VHA) policy.
- Ensure that registered nurses (RN) who work in the urgent care center (UCC) achieve the required clinical competencies annually.

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

- Coordination of Care.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Linda G. DeLong, Director, Dallas 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 Veterans Rural Access Hospital located in Big Spring, TX, that provides a limited range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics in Abilene, Fort Stockton, Odessa, Stamford, and San Angelo, TX, and in Hobbs, NM. The system is part of VISN 18 and serves a veteran population of more than 59,000 in 32 counties in Texas and 1 county in New Mexico.

Programs. The system provides outpatient services in the areas of medicine, rehabilitation, and dentistry and inpatient services in the areas of medicine, domiciliary care, and extended care. It also provides fee based community services and referrals to other VISN 18 facilities. The system has 25 hospital beds and 40 community living center (CLC)[1] beds. The domiciliary is currently a temporary 12-bed unit until the permanent 40-bed unit is constructed.

Affiliations and Research. The system is affiliated with Texas Tech University Health Sciences Center, the University of Houston, Angelo State University, New Mexico State University, and the University of Utah. It provides training for one medicine resident and two ophthalmology residents. Currently, the system does not have a research program.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $83.4 million. The FY 2009 medical care budget is $87.8 million. FY 2008 staffing was 503 full-time employee equivalents (FTE), including 23 physician and 139 nursing FTE.

Workload. In FY 2008, the system treated 17,545 unique patients and provided 1,979 inpatient days in the hospital and 10,068 days in the CLC. The inpatient care workload totaled 713 discharges, and the average daily census, including CLC patients, was 33. Outpatient workload totaled 142,630 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 eight activities:

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

The review covered system operations for FY 2008 and FY 2009 through December 1, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. Also, we followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas,* Report No. 06-00661-175,

July 24, 2006). The system had corrected all findings related to health care from our prior CAP review.

We also followed up on recommendations from two reports by VHA's Office of the Medical Inspector (OMI) (*Final Report: Review of Complaints Regarding the Quality of Medical Care, West Texas VA Health Care System, Big Spring, Texas*, February 26, 2003; *Final Report: Review of the Surgical Service, West Texas VA Health Care System, Big Spring, Texas*, August 14, 2003). In the first report, the OMI made recommendations to improve patient and staff safety, access to care, system leadership, and the quality of medical care. In the second report, the OMI made recommendations to improve or discontinue surgical services at the system. For both reports, we reviewed documentation of the system's follow-up. We found the improvement actions to be acceptable, and we consider the OMI recommendations closed for both reports.

During this review, we presented fraud and integrity awareness briefings for 117 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 system had a comprehensive QM program designed to monitor patient care and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents. We interviewed appropriate senior managers and the QM Coordinator.

The system'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 the following areas that needed improvement.

Patient Safety. In order to minimize inadvertent harm to patients consequent to their medical care and as part of VHA's patient safety improvement initiatives, VHA policy[2] requires that RCAs be completed. The system completed eight individual RCAs in the last 12 months; however, three of the eight did not meet the 45-day timeframe established by VHA.

Medical Records Review. Health Information Management Service had not ensured that medical records were reviewed on an ongoing basis at the point of care by providers who document in the record. A representative sample of inpatient and outpatient records from each service must be reviewed to ensure that adequate, timely, complete, and properly authenticated documentation is being accomplished in accordance with Joint Commission (JC) standards and VHA policy.[3]

Also, the system's local policy states when it is appropriate to copy information from one part of the medical record to a current progress note. However, the system did not monitor this function to identify violations.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires that RCAs are completed within 45 days, in accordance with VHA policy.

The VISN and System Directors concurred with the finding and recommendation. The system implemented an action plan. All RCAs chartered since March 2008 have been completed within 45 days. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2

We recommended that the VISN Director ensure that the System Director requires that medical records are reviewed on an ongoing basis at the point of care by providers who document in the record, in accordance with VHA policy.

The VISN and System Directors concurred with the finding and recommendation. The Chief of Health Information Management Service will identify encounters for each

[2] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* May 23, 2008.
[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

physician to review. The results of these monthly reviews will be reported on a quarterly basis to the Clinical Executive Board (CEB). QM will conduct monthly inpatient reviews. The results of inpatient reviews will be reported monthly to the Medical Records Review Committee and quarterly to the CEB. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3

We recommended that the VISN Director ensure that the System Director requires that the copy and paste function in the electronic medical record is monitored to identify violations, in accordance with local policy.

The VISN and System Directors concurred with the finding and recommendation. Coders will review progress notes monthly to ensure that copy and paste activities are conducted in accordance with local policy. The corrective action is acceptable, and we consider this recommendation closed.

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 on the medicine unit and the CLC. We found appropriate use of patient armbands to correctly identify patients prior to medication administration, and we determined that self-medication administrations were completed safely and accurately. However, we identified an issue that needed improvement.

Pain Medication Effectiveness. VHA regulations[4] and local policy require that the effects of pain medications be monitored. Local policy defined an appropriate timeframe for documentation of pain medication effectiveness. We found that 44 (49 percent) of 89 administered doses of pain medications were documented for effectiveness. We noted that of those 44 doses, 23 (52 percent) met the timeframe outlined in local policy for documentation of patient response. Without appropriate documentation and follow-up, clinicians could not be assured that patients' pain was effectively managed.

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[4] VHA Directive 2003-021, *Pain Management*, May 2, 2003.

Recommendation 4

We recommended that the VISN Director ensure that the System Director requires clinicians to document pain medication effectiveness in a timely manner.

The VISN and System Directors concurred with the findings and recommendation. Charge nurses will utilize narcotic administration reports to verify that pain assessments are documented in a timely manner. Night shift charge nurses will conduct 24-hour reviews of all administered pain medications to ensure that pain assessments are documented in the Bar Code Medication Administration system. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the system maintained a safe and clean health care environment. The system is required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and JC 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 medicine unit, the CLC, and primary care and specialty clinics. The system was generally clean and effectively maintained. Managers and staff were responsive to environmental concerns identified during our inspection, and those concerns were resolved while we were onsite. The IC program monitored and reported data to clinicians for implementation of quality improvements. However, we identified the following conditions that needed improvement.

Environmental Rounds. Environmental rounds conducted by the system's inspection team allow each discipline participating to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the system in depth. A Deputy Under Secretary for Health for Operations and Management memorandum issued on March 5, 2007, requires the Information Security Officer (ISO) to be included as a team member on EOC rounds. The ISO or the ISO's designee participated in 11 (24 percent) of 46 weeks of EOC rounds.

Safety. To minimize the risk of patients wandering away from designated areas, VHA policy[5] outlines standards for monitoring and maintaining electronic systems, such as the WanderGuard®. A basic system check should occur every 24 hours to assure proper functioning. Maintenance of the WanderGuard® system should be consistent with the manufacturer's guidelines, and a complete check must be performed annually. The system implemented the WanderGuard® system about 6 months ago; however, local policy did not clearly designate responsibility for monitoring and maintaining the system on the CLC unit. The local policy was revised while we were onsite.

Environment of Care Deficiency Monitors. EOC inspections identify concerns for appropriate actions. VHA facilities are required to inspect administrative and clinical areas semi-annually to identify environmental deficiencies and initiate timely resolutions. VHA facilities are required to develop a tool to track and trend EOC inspections, deficiencies identified, and corrective actions taken. The target score for EOC performance measures (PMs) is 85 percent or better. The system did not meet the target score for deficiencies corrected within 14 days. In addition, the system did not meet the target score for deficiencies that cannot be corrected within 14 days but have been addressed with a plan for action. However, the system had recognized the issue and had implemented corrective actions.

Infection Control. Methods are required to reduce the risks of infection associated with cross-contamination, and there are systems in place to communicate with staff about their responsibilities in preventing the spread of infection. We found clean supplies and dirty linens in close proximity in the same rooms. This same issue was a finding in the 2006 and 2007 Annual Workplace Evaluations. While we were onsite, managers moved the clean supplies to different rooms.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that identified EOC deficiencies are corrected.

The VISN and System Directors concurred with the findings and recommendation. Follow-up EOC rounds have been rescheduled for 11 days after initial rounds to allow time for reported deficiencies to be corrected. The ISO will

[5] VHA Directive 2008-057, *Management of Wandering and Missing Patient Events*, September 23, 2008.

participate on follow-up rounds to eliminate scheduling conflicts with initial rounds. Service chiefs now receive weekly progress reports on the correction of EOC deficiencies, and the system met the PMs for 85 percent completion for the 4th quarter of FY 2008. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations and Controlled Substances Inspections

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations[6] governing pharmacy and CS security, and we assessed whether the system's policies and practices were consistent with VHA requirements. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns. Additionally, we reviewed policies and procedures and interviewed the CS Coordinator, pharmacy managers, and the Chief of Police Service.

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.[7] Some literature suggests that that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[8] Our review showed that managers followed processes to ensure that medication regimens were

[6] 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.

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

[8] 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.

reviewed for patients who were prescribed multiple medications to avoid polypharmacy.

CS inspections were conducted monthly, in accordance with VHA regulations. Training records showed that the CS Coordinator and inspectors received appropriate training to execute their duties. We also found that managers reported all CS diversions or suspected diversions to the OIG. The pharmacies' internal environments were clean and well maintained. However, our reviewed showed that managers needed to improve in the following area.

Monthly Controlled Substances Inspections. We reviewed documentation for six monthly CS inspections completed May–October 2008. In two of the months reviewed, the CS inspections were not completed on the same day initiated, as required by VHA policy.[9]

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that monthly CS inspections are completed the day initiated, as required by VHA policy.

The VISN and System Directors concurred with the finding and recommendation. The CS Coordinator will adhere to the requirement that CS inspectors complete CS inspections the same day initiated and will instruct CS inspectors to check in by noon the day of inspection to avert any potential delays. The corrective action is acceptable, and we consider this recommendation closed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of patient care and operations in VHA emergency departments (EDs) and UCCs, such as clinical services, consults, transfers, discharges, staffing, and staff competencies. We also determined whether the physical environment was clean and safe and whether managers maintained equipment appropriately. The system did not have an ED but did have a UCC that was open 7 days a week, 24 hours a day.

We interviewed the UCC nurse manager, transfer coordinators, and the system's Director. We reviewed policies and other pertinent documents, including equipment maintenance records. We reviewed medical records of patients with consults to other VHA facilities within the VISN

[9] VHA Handbook 1108.2.

and medical records of patients transferred to other medical facilities. Our review showed that consults, transfers, and staffing were appropriate. Our EOC rounds revealed a clean and safe environment, and we found that managers appropriately maintained equipment. We identified one area that needed improvement.

Competencies. We reviewed the competency files and training summaries of three RNs who worked in the UCC, and we interviewed nurse managers. VHA policy[10] and JC standards require that nursing staff assignments be congruent with patient care needs and employee qualifications. The system required that UCC RNs achieve certain competencies annually. These competencies were the performance of: (a) glucose testing, (b) electrocardiograms, and (c) breathalyzer[11] tests. Interviews and our review of the files revealed that:

- None of the three RNs had current competencies for breathalyzer tests.
- Two of the RNs did not have copies of current nursing licensure in their competency files.

Recommendation 7

We recommended that the VISN Director ensure that the System Director requires that RNs who work in the UCC achieve the required clinical competencies annually.

The VISN and System Directors concurred with the findings and recommendation. The UCC nurse manager will implement a competency spreadsheet for initial employment and will use this spreadsheet to track required annual reviews. The spreadsheet will also be used to schedule annual clinical competency reviews before their due dates. 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 VHA facilities had adequate processes to ensure coordination of care across the continuum of patient services. We reviewed three aspects of care: (a) patient consults, (b) patient intra-facility transfers, and (c) patient discharges. We found

[10] VHA Manual M-2, Part V; *Clinical Affairs, Nursing Service;* July 13, 1989.
[11] The breathalyzer is a device that measures the alcohol content of an individual's breath and estimates the amount of alcohol in the blood.

that providers managed patient consults, intra-facility transfers, and discharges appropriately. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive nurse staffing guidelines and whether the guidelines had been met. We reviewed nurse staffing documents for all 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 facilities use quarterly survey results of patients' health care experiences with the VHA system 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 PM target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Facilities are expected to address areas that fall below target scores. Figures 1 and 2 on the next page show the system's SHEP PM results for inpatients and outpatients, respectively.

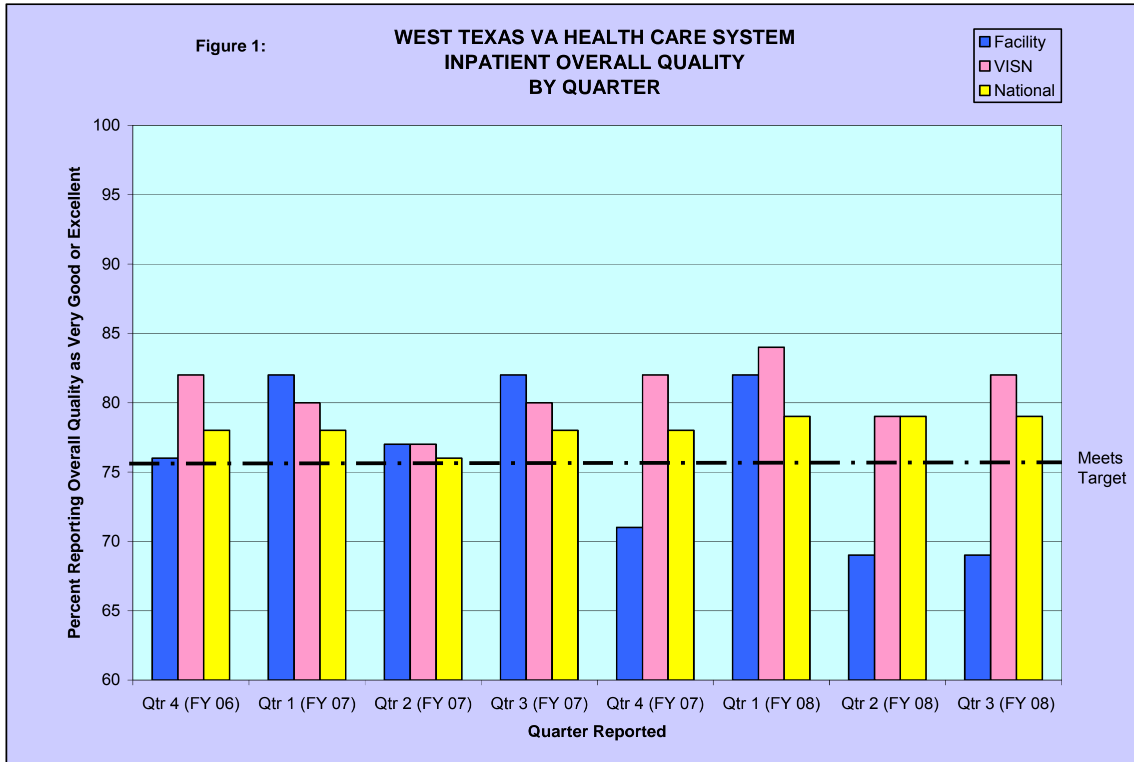
Figure 1:
WEST TEXAS VA HEALTH CARE SYSTEM
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

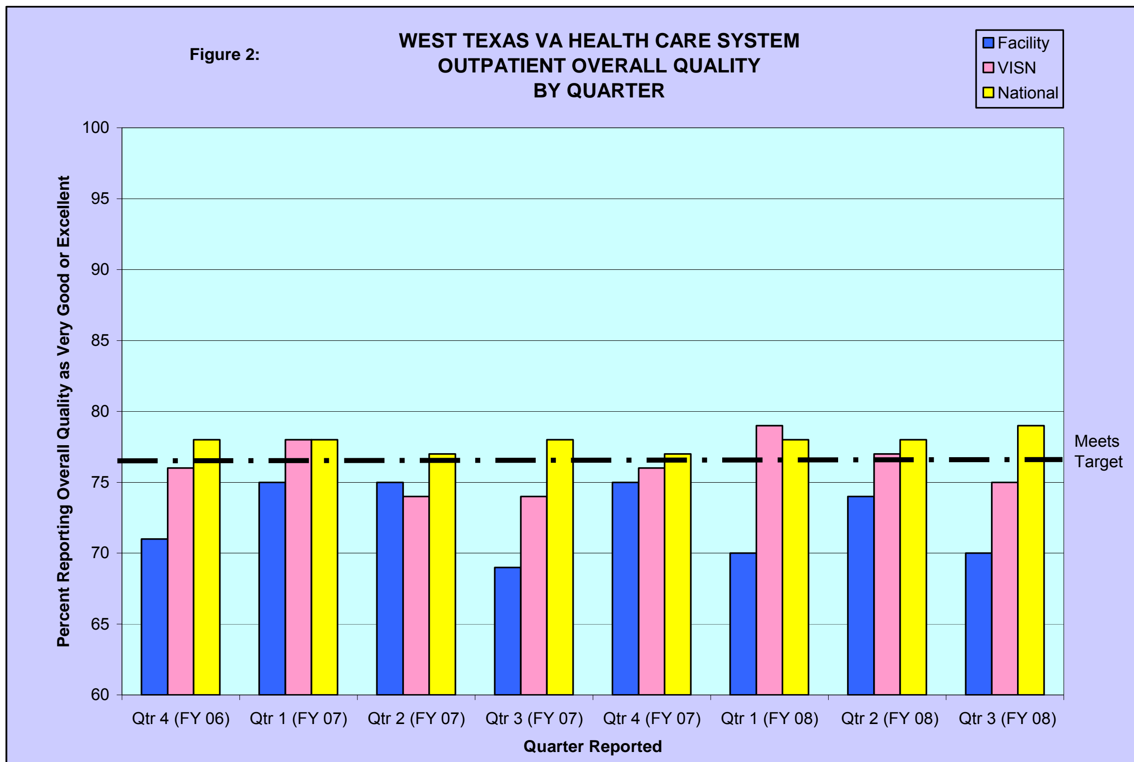
Figure 2:
WEST TEXAS VA HEALTH CARE SYSTEM
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Qtr 3 (FY 08)
Quarter Reported

The system did not meet the established target for 3 of the last 8 quarters of available data for inpatient overall satisfaction and all of the last 8 quarters for outpatient overall satisfaction. However, managers had identified opportunities for improvement based on the SHEP scores and had developed action plans targeting specific services and departments. Staff provided documentation for the implementation of action plans, ongoing activities, and action plan effectiveness for areas that fell below the target scores. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2009

From: Director, VA Southwest Health Care Network (10N/18)

Subject: **Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas**

To: Director Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (10B5)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program review at the West Texas VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

(original signed by:)

Susan P. Bowers

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 5, 2009

From: Director, West Texas VA Health Care System (519/00)

Subject: **Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas**

To: **Director, Dallas Healthcare Inspections Division (54DA)**

I take this opportunity to thank the Office of Inspector General Combined Assessment Program (CAP) Survey Team for a professional, comprehensive, impartial, and educational survey conducted December 1–5, 2008. I appreciate the opportunity to provide comments to the report of the OIG CAP review of the West Texas VA Health Care System (WTVAHCS). I concur with the findings and the recommendations for improvement. The WTVAHCS staff have already begun corrective actions on all recommendations.

The WTVAHCS staff are pleased with the results and improvements that resulted from the survey findings. The collaborative efforts of the experts on the CAP review team have contributed to improvements in the level of care, safety, and services that WTVAHCS provides our veterans.

DANIEL MARSH

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 System Director requires that RCAs are completed within 45 days, in accordance with VHA policy.

Concur.

The VISN Director emphasized the commitment to complete RCAs within 45 days and WTVAHCS implemented an action plan. All RCAs chartered since March 2008 were completed within 45 days. WTVAHCS received the Bronze RCA Cornerstone Recognition Award in FY2008 for completing four RCAs and four Aggregate RCAs within 45 days.

Target Completion Date: Completed.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that medical records are reviewed on an ongoing basis at the point of care by providers who document in the record, in accordance with VHA policy.

Concur.

The Chief of Health Information Management System will identify encounters for each physician to review on a monthly basis for clinical pertinence, quality, and appropriateness of care. Physicians will conduct monthly reviews that will be reported on a quarterly basis to the Clinical Executive Board (CEB). Quality Management will conduct inpatient point of care reviews on ten records monthly using a record review checklist. Review results will be reported to the Medical Records Review Committee monthly and to CEB on a quarterly basis.

Target Completion Date: January 2009.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that the copy and paste function in the electronic medical record is monitored to identify violations, in accordance with local policy.

Concur.

WTVAHCS coders will review 50 progress notes monthly to ensure that copy and paste activities are conducted in accordance to criteria established in MCM 11-71 Copying, Pasting and Template Use. Results of the reviews will be submitted to Medical Record Review Committee and Medical Staff Committee on a monthly basis.

Target Completion Date: Completed.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires clinicians to document pain medication effectiveness in a timely manner.

Concur.

Local policy was in place with appropriate requirements, but it was not being followed. Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) have completed re-education on the policy and will comply. Charge Nurses will utilize narcotic administration reports to verify pain assessments are documented in a timely manner. The night shift Charge Nurses will conduct a 24-hour review of all administered pain medications to ensure pain assessments are documented in the Bar Code Medication Administration system. Monthly reports will be reviewed at unit staff meetings; quarterly reports will be reviewed by the Nurse Executive Board and forwarded to the Nurse-Pharmacy liaison qu00arterly.

Target Completion Date: January 2009.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires identified EOC deficiencies are corrected.

Concur.

Follow-up rounds were rescheduled to be conducted 11 days after initial rounds to allow time for reported deficiencies to be corrected. The Chief of Environmental Services reports 100% of outstanding deficiencies to the Administrative Executive Board through the Environment of Care Committee. Weekly progress reports on correction of EOC deficiencies are provided to Service Chiefs. Performance monitor for 85% completion rate was met fourth quarter of FY08. The Information Security Officer will participate on follow-up EOC rounds on Mondays to eliminate schedule conflicts with initial rounds on Thursdays.

Target Completion Date: Completed.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that monthly CS inspections are completed the day initiated, as required by VHA policy.

Concur.

The Controlled Substance (CS) Coordinator will follow the VHA policy requirement for CS inspectors to complete CS inspections the same day and instruct CS inspectors to check in no later than noon the day of inspection to avert any potential delays. The CS Inspectors advise the CS Coordinator no later than noon on the day of inspection about progress and/or potential for delays. Results: All CS inspections since August 2008 have been conducted and completed on the same day.

Target Completion Date: Completed.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that RNs who work in the UCC achieve the required clinical competencies annually.

Concur.

The Urgent Care Center (UCC) Nurse Manager (NM) will implement a competency spreadsheet for initial employment and to track required annual reviews that will include Alcohol Strip Testing. The UCC NM will complete an annual review of competency requirements with 100% of registered nurses who work in UCC. On a quarterly basis, the spreadsheet will be used to schedule clinical competency reviews before their annual due date expires.

Implementation Date: January 15, 2009.

OIG Contact and Staff Acknowledgments

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Report Distribution

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