



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 08-02871-52

Combined Assessment Program Review of the VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania



January 13, 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 September 8–12, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Pittsburgh Healthcare System (the system), Pittsburgh, PA. 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 259 system employees. The system is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

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

- Recipient of two 2008 VA Office of Nursing Service Innovation Awards.
- The Chief of Staff was the recipient of a 2008 Service to America Medal (Sammie).

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

- Ensure that Customer Service Committee minutes are reviewed by a senior level committee to track, trend, and analyze all patient satisfaction data.
- Develop a policy for the copying and pasting of text in the electronic medical record and implement a process to monitor these functions.
- Ensure that all Environmental Management Service (EMS) employees receive the required *Clostridium difficile* environmental cleaning and infection control (IC) training.
- Correct the identified environment of care (EOC) issues.
- Complete discharge summaries and ensure that they are consistent with the discharge instructions provided to patients.
- Establish a policy to resolve the conflict between the electronic medical record template and the policy concerning pain assessment and documentation.
- Revise the system's Bar Code Medication Administration (BCMA) policy to reflect the current practice.

- Ensure that all inter-facility transfer documentation complies with Veterans Health Administration (VHA) policy.
- Ensure that critical equipment monitoring is performed and documented.
- Ensure that nursing staff point-of-care competency certification documentation is complete.

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

- Patient Satisfaction Survey Scores.
- Pharmacy Operations.
- Staffing.

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

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 15–19, for the full text of the Directors’ comments.) We will follow up on the planned actions until they are completed.

*(original signed by Dana Moore, Ph.D.,
Deputy Assistant Inspector General for
Healthcare Inspections for:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system has three divisions located in Pittsburgh, PA, and provides major medical and surgical inpatient and outpatient care. It is a national referral center for cardiac surgery and for liver and kidney transplants. Outpatient care is also provided at five community based outpatient clinics in Monaca, Greensburg, Washington, and Uniontown, PA, and in St. Clairsville, OH. The system is part of VISN 4 and serves a veteran population of more than 273,000 in a primary service area that includes 17 counties in western Pennsylvania, 3 counties in West Virginia, and 1 county in Ohio.

Programs. The system provides medical, surgical, mental health, long-term care, and home care services. It has 177 hospital beds and 262 community living center (CLC) beds.¹

Affiliations and Research. The system's primary academic affiliation is with the University of Pittsburgh Medical Center's Medical Education Program. The system supports 121 medical resident positions, five dental trainee positions, and 65 associated health positions. In fiscal year (FY) 2007, the system's research program had 333 projects and a budget of \$24.3 million. Important areas of research include behavioral therapy, diabetes, geriatrics, health services, hematology/oncology, infectious diseases, kidney dialysis, neurology, neurocognition, pulmonary diseases, and speech pathology.

Resources. In FY 2007, medical care expenditures totaled \$366 million. The FY 2008 medical care budget was \$456 million. FY 2007 staffing was 2,589 full-time employee equivalents (FTE), including 123 physician and 653 nursing FTE.

Workload. In FY 2007, the system treated 58,869 unique patients and provided 73,292 inpatient days in the hospital, 85,347 inpatient days in the CLC, and 19,996 patient days in the domiciliary. The inpatient care workload totaled 7,594 hospital discharges, 918 CLC discharges, and 450 domiciliary discharges. The average daily census,

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.

including inpatients, CLC patients, and domiciliary patients, was 489.4. Outpatient workload totaled 489,814 visits.

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.
- Patient Satisfaction Survey Scores.
- Pharmacy Operations.
- QM.
- Staffing.

The review covered system operations for FY 2007 and FY 2008 through September 1, 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 Pittsburgh Health*

Care System, Pittsburgh, Pennsylvania, Report No. 05-01241-174, July 19, 2005.) All health care related findings from our prior CAP review had been corrected.

During this review, we also presented fraud and integrity awareness briefings for 259 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.

Organizational Strengths

VA Office of Nursing Service Innovation Awards

The system received two VA Office of Nursing Service Innovation Awards for FY 2008. The first award was received for improved glycemic control in veterans undergoing cardiac bypass who developed deep sternal surgical site infections at an increased rate. A workgroup discovered that in all patients who had developed mediastinitis (an inflammation of tissues in the mid chest) and significant post-operative hyperglycemia, available glycemic protocols were either inadequate to meet patients' needs or so complicated that they were prone to error. In response to these findings, a team of nurses designed and educated their colleagues on a usable patient-focused tight glucose control system. Within the first month, improvement occurred. Ongoing performance improvement work resulted in GENIE (Glycemic Expert for Nurse Implemented Euglycemia), a computer interface that allows for precise glucose management, which is soon to be patented.

The second award was received for improving early detection and case management of colorectal cancer. In order to improve screening compliance and patient access to the gastroenterology (GI) clinic and laboratory, the staffing methodology and care delivery model were structurally redesigned. Some resulting changes included having a nurse call patients 3 days pre-procedure to review preparation instructions, training nurses in intravenous (IV) administration to eliminate delays, adding more escort staff to facilitate transportation, and hiring a nurse practitioner as a colorectal cancer coordinator to improve the processing of

patients with positive fecal occult blood test results. As a result, colorectal cancer screening rates increased from 50 to 76 percent, productivity in the GI laboratory improved by 23 percent, and waiting times were reduced to 12 days.

**Chief of Staff
Receives the
Service to America
Medal**

The system's Chief of Staff was awarded the Sammie in the Citizen Services category. The Chief of Staff won this award for his leadership of the methicillin-resistant *Staphylococcus aureus* prevention initiative, which is used locally by the system and nationally by VA and non-VA health care institutions. The program is a model for how health care organizations can eliminate hospital-acquired infections.

Results

Review Activities With Recommendations

**Quality
Management**

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, and Chief Nurse Executive, and we interviewed QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care in the system. However, we identified the following areas that needed improvement.

Patient Complaints. VHA policy² requires that patient complaint and patient satisfaction data be collected, trended, and analyzed and included along with other quality improvement data for discussion in the appropriate facility committees and forums. Until recently, the system had only one patient advocate who was responsible for the entire system and who served as the chairperson of the Customer Service Committee. Analyses of patient complaint and customer service data to identify significant trends did not occur in the Customer Service Committee. Also, the Customer Service Committee minutes were not reviewed by a senior level committee within the system.

Copying and Pasting of Text. The electronic medical record system allows copying and pasting of text, but VHA policy states that these functions should be used with caution. We

² VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

found that the system did not comply with VHA requirements³ to develop a policy regarding the copying and pasting of text in the electronic medical record and to monitor the practice as part of the ongoing medical record review process. Routine copying and pasting of text can result in confusing and misleading medical information that could negatively impact patient care. Without adequate medical record reviews, managers could not be assured that the copy and paste functions were being appropriately used at the system.

Recommendation 1 We recommended that the VISN Director ensure that the System Director ensures that Customer Service Committee minutes are reviewed by a senior level committee and that the Customer Service Committee track, trend, and analyze all patient satisfaction data.

Recommendation 2 We recommended that the VISN Director ensure that the System Director ensures that a policy is developed regarding the copying and pasting of text in the electronic medical record and that a process to monitor copying and pasting in the electronic medical record is implemented.

The VISN and System Directors concurred with the findings and recommendations and have implemented the following actions. A patient satisfaction data report has been developed that displays data pertaining to performance measures and dimensions of care. Staff are working to create a retrospective report to track trends over time. Once trends are identified, the data will be used to target areas in which satisfaction is not meeting expectations. Customer Service Committee minutes have been added to the Clinical Executive Leadership Board reporting schedule for review. Policy IM-037, *Copying and Pasting of Medical Record Documentation*, was developed. A process was implemented to monitor copying and pasting in the electronic medical record. The results are reviewed by the Clinical Informatics Committee. 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 if the system complied with selected IC standards and maintained a clean, safe, and secure environment. VHA facilities are required to

³ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

establish a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff. Additionally, we reviewed the locked acute inpatient behavioral health unit to determine if the Multidisciplinary Safety Inspection Team (MSIT) identified and mitigated environmental hazards that pose a threat to patients and to ensure that the team and staff received specialized training. We found that the MSIT and staff of the locked acute inpatient behavioral health unit, located at the Highland Drive division, received comprehensive training, and as a result, met the VHA National Center for Patient Safety goals.

We inspected the medical intensive care unit (MICU), 6 West (liver transplant and medical-surgical unit), two units in the CLC, the dialysis unit, the chemotherapy unit, and the radiation therapy unit. The facility was generally clean and well maintained. We identified the following conditions that required attention:

- Cardboard boxes stored on the floor and soiled ceiling tiles in various areas of the system.
- MICU cleanliness.
- Incomplete *Clostridium difficile*⁴ environmental cleaning and IC training, which is required for all EMS employees.
- Improperly sealed construction barriers.
- No lock on one construction access door.
- Unsecured access to soiled utility rooms.

While we were onsite, managers took immediate actions to correct these deficiencies.

Recommendation 3

We recommended that the VISN Director ensure that the System Director ensures that all EMS employees receive the required *Clostridium difficile* environmental cleaning and IC training.

⁴ *Clostridium difficile* is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Illness from *Clostridium difficile* most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after the use of antibiotic medications.

Recommendation 4

We recommended that the VISN Director ensure that the System Director ensures that the identified EOC issues are addressed and that action plans are implemented.

The VISN and System Directors concurred with the findings and recommendations and have implemented the following actions. The annual training for all EMS employees includes the required *Clostridium difficile* environmental cleaning and IC training. During the CAP review, electronic training records from the Learning Management System were not retrievable, and there were no hard copies of the training available. EMS leadership has implemented an education tracking system. EOC issues were addressed, and action plans have been implemented. Cleaning in the MICU was completed September 15, 2008. All EMS staff assigned to the MICU have been retrained on the appropriate cleaning methods for this unit. The contractor sealed the door and placed a keypad lock on the construction access door. All utility rooms were checked, and all have locking hardware and the capability to be locked. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

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

We found timely responses to 13 (100 percent) of 13 inpatient consultations reviewed. Nursing assessments were completed within required timeframes for the 12 intra-facility transfers reviewed. Also, we found sending unit to receiving unit notes by providers and nurses in 10 (83 percent) of the 12 records we reviewed. We identified the one area that needed improvement.

Discharges. Physicians are required to complete a discharge summary within 30 days of discharge. We reviewed 12 hospital stays and found that 10 (83 percent) of the 12 discharge summaries we reviewed were completed within the required timeframe. Two discharge summaries were not completed at all.

Patients are to receive printed discharge instructions detailing the follow-up schedule and the medications,

activities, and diet prescribed for home. Documentation of the instructions given and the patient's understanding are required. We found that discharge instructions were appropriately documented in 10 (83 percent) of 12 records reviewed. Of those 10 records, 5 (50 percent) contained inconsistencies between patient discharge instructions and the discharge summaries. There were discrepancies in diet, activity level allowed, and medications.

Recommendation 5

We recommended that the VISN Director ensure that the System Director ensures that discharge summaries are completed, as required, and that they are consistent with the discharge instructions provided to patients.

The VISN and System Directors concurred with the findings and recommendations and have implemented the following actions. All nursing staff were reminded to consistently complete discharge instructions for each patient. A review of post-discharge phone calls from September 1, 2008, to November 7, 2008, revealed that 100 percent of the time, printed discharge instructions were reviewed and given to the patient. Timely completion of medical records is used in provider-specific data for reprivileging. The clinical pertinence review tool has been revised to include a review of discharge summaries in correlation with discharge instructions for consistency of information. 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 facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes in an acute inpatient medical-surgical unit, the MICU, the CLC, and the locked acute inpatient behavioral health unit.

We found adequate management of medications brought into the facility by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. Pharmacists reviewed all medication orders, and qualified pharmacists were available by phone when the pharmacies were closed. We observed appropriate use of BCMA to correctly identify patients prior to medication administration, and we found that the reconciliation of controlled substances (CS) discrepancies at

the unit level was adequate. We identified two areas that needed improvement.

Pain Management Effectiveness. The system's pain management policy states that when PRN (as needed) opioids and PRN non-opioids are administered, the patient's response to the medication must be assessed. Documentation of the assessment must occur within 4 hours in all cases. However, the electronic medical record template automatically documents assessments as occurring at 1 hour post-administration. We reviewed 18 patient's electronic medical records and 47 pain assessments for those patients. Thirty-four (72 percent) of the 47 assessments were documented within the 4-hour standard. Also, we found two assessments where documentation actually occurred within 15 to 20 minutes, but the template language indicated pain assessments at 1 hour post-administration.

Controlled Substances Discrepancies. The system's policy states that when a discrepancy in narcotic administration occurs, the nurse manager will obtain a written report of discrepancy (resolved or unresolved) signed by the nurse involved and by a nurse witness. We found inconsistent recordkeeping on the units we visited. This was most likely due to updates and revisions in the automated medication dispensing system, which electronically records the witnesses and the reason for the discrepancy.

Recommendation 6 We recommended that the VISN Director ensure that the System Director establishes a policy to resolve the conflict between the electronic medical record template and the policy concerning PRN pain assessment and documentation.

Recommendation 7 We recommended that the VISN Director ensure that the System Director revises the current BCMA policy to reflect the current practice.

The VISN and System Directors concurred with the findings and recommendations and have implemented the following actions. The pain assessment template was revised. Registered nurses will specifically document numerical pain scores, dates, and times. The change has been reviewed with all nursing staff. No change was made to the policy because the template change resolved the conflict. System policy has been revised to reflect the current practice in resolving automated medication dispensing system

discrepancies. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations, such as clinical services, consults, inter-facility transfers, staffing, and staff competencies, in VHA emergency departments (EDs). We also determined whether the physical environment was clean and safe and whether equipment was appropriately maintained.

We interviewed physicians, the ED program manager, and others from the Critical Care Service Line. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. We reviewed the medical records of patients who were transferred to other medical facilities or admitted to inpatient units within the system.

Our review showed that clinical services, consults, and staffing were appropriate. Emergency services provided are within the system's patient care capabilities. In addition, we found appropriate policies for managing patients whose care may exceed the system's capability.

We conducted an EOC tour and found that the ED was clean and safe. Also, the ED has two treatment rooms that can be converted to mental health observation rooms, thus maximizing the utility of the rooms while ensuring patient safety. The following areas needed improvement.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ED to other medical facilities for care. Transfer documentation did not comply with VHA policy,⁵ which requires the use of VA Form 10-2649A, "Inter-Facility Transfer Form," and/or the appropriate electronic medical record template note.

Equipment Monitoring. During our EOC tour of the ED, we found that the defibrillator checklist was signed, indicating that a nurse had completed the daily checks. However, when we reviewed the strip that is run as a part of the check, it was dated 3 days prior to the signed checklist.

⁵ VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Point-of-Care Testing. When we reviewed nursing staff competency data, we found that two out of the three nurses had not completed the point-of-care certification.

Recommendation 8 We recommended that the VISN Director ensure that the System Director ensures that all inter-facility transfer documentation complies with VHA policy.

Recommendation 9 We recommended that the VISN Director ensure that the System Director ensures that critical equipment monitoring is performed and documented, as required by system policy.

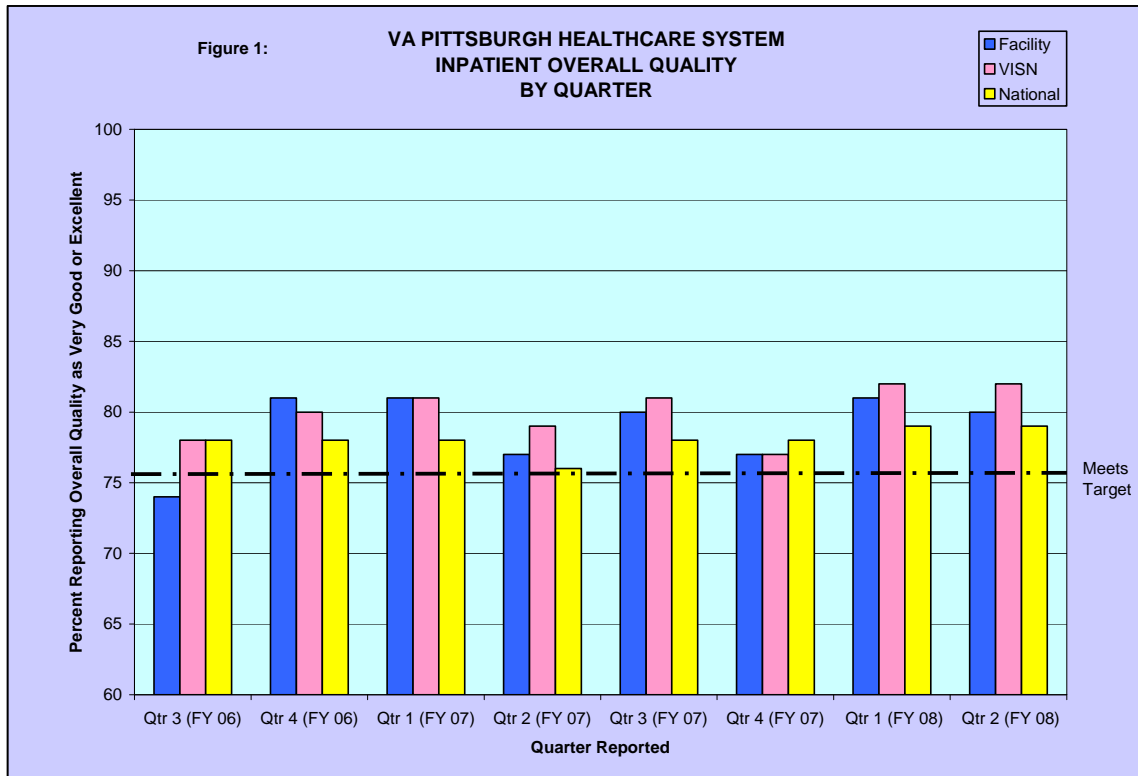
Recommendation 10 We recommended that the VISN Director ensure that the System Director ensures that all nursing staff point-of-care competency certification documentation is complete.

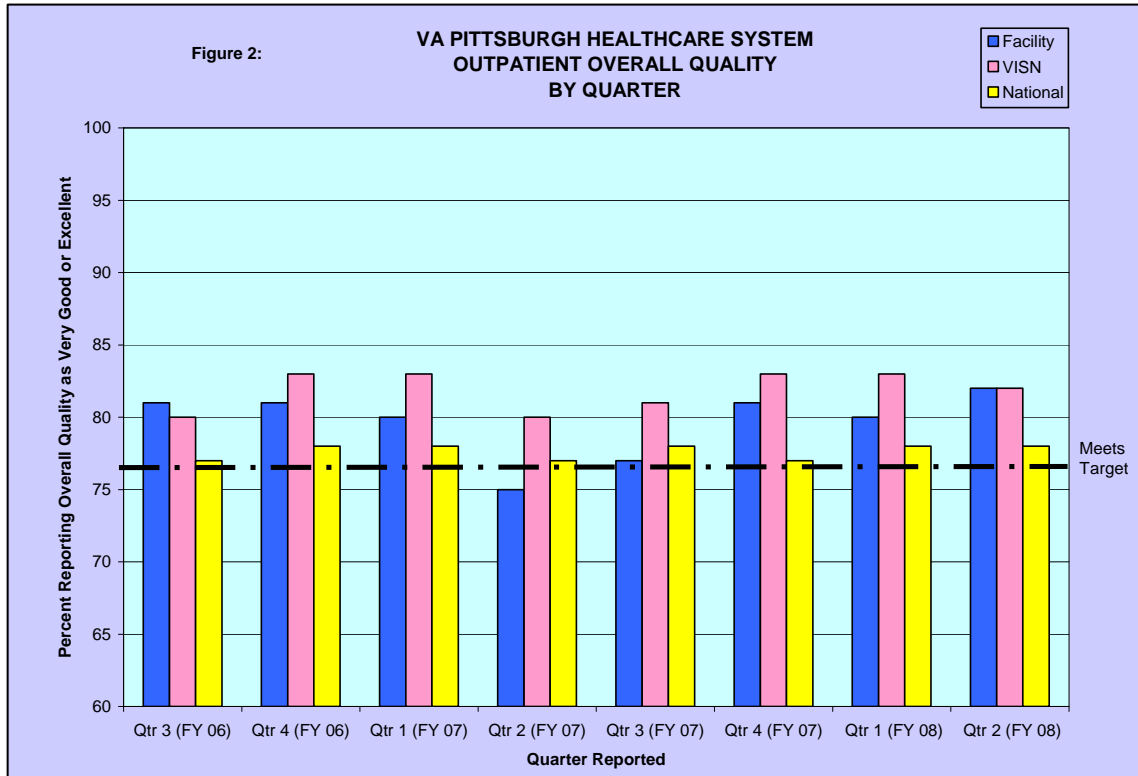
The VISN and System Directors concurred with the findings and recommendations and have implemented the following actions. The ED Medical Director has reviewed with all ED providers the requirement to complete the transfer note template in the electronic medical record for all patients who are transferred from the ED to another facility. A review of this requirement will be incorporated into the orientation for all new ED providers. Compliance is being monitored by the ED Medical Director. The responsibility to check all defibrillators daily was reviewed with all ED registered nurses. Defibrillator checklists from September 1, 2008, to November 7, 2008, have been appropriately completed. As of October 24, 2008, all ED nursing staff who perform point-of-care testing had completed point-of-care competency validation. Records have been updated and are available in the Critical Care Education Office. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Patient Satisfaction Survey Scores The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figures 1 and 2 below and on the next page show the system's patient satisfaction performance measure results for inpatients and outpatients, respectively. The system's inpatient scores met or exceeded the target in all but 1 quarter. The system's outpatient scores also met or exceeded the target in all but 1 quarter. Therefore, we made no recommendations.





Pharmacy Operations

The purpose of this review was to evaluate whether the system had adequate controls to ensure the security and proper management of CS and to inspect 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 assessed whether the policies and practices of the system were consistent with VHA regulations governing inspection of CS in the inpatient and outpatient pharmacy settings. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns. We interviewed appropriate Pharmacy Service and Police and Security Service personnel as necessary. We also reviewed policies and procedures and interviewed appropriate personnel to determine whether clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. We found that the system had appropriate policies and procedures to ensure the security of the pharmacies and CS. CS inspections were conducted according to VHA regulations. Training records showed that the CS Coordinator and the inspectors received appropriate

training to execute their duties. We also found that managers reported all CS diversions or suspected diversions to the OIG. The clean room, where sterile intravenous medications were prepared, complied with VHA regulations and IC standards.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and treat disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy includes the administration of medications that have no apparent indication, medications that interact with other prescribed drugs, inappropriate medication dosages, and medications to treat adverse drug reactions. Elderly and mental health patients are among the most vulnerable populations for polypharmacy.

Our review showed that managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the system had developed staffing guidelines for nurses, and we found them to be adequate. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 5, 2008

From: VISN Director

Subject: **Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania**

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

Director, Management Review Service (10B5)

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

(original signed by:)

MICHAEL E. MORELAND, FACHE
Network Director

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 5, 2008
From: System Director (00/646)
Subject: **Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania**
To: Network Director, VA Pittsburgh Healthcare System, (VISN 4) (10N4)

Listed below are the completed actions for the 10 recommendations received from the Office of the Inspector General at the VA Pittsburgh Healthcare System Combined Assessment Program review during the week of September 8–12, 2008. The facility concurs with all of the recommendations.

(original signed by:)

TERRY GERIGK WOLF, FACHE

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 ensures that Customer Service Committee minutes are reviewed by a senior level committee and that the Customer Service Committee track, trend, and analyze all patient satisfaction data.

Concur

Target Completion Date: Completed

A red/green SHEP data report has been developed displaying data pertaining to performance measures and dimensions of care. Staff is working with ProClarity to create a retrospective red/green report to track trends over time. Once trends are identified the PATS data will be used to target areas in which satisfaction is not meeting expectations. The Customer Service Council Minutes have been added to the Clinical Executive Leadership Board reporting schedule for bimonthly review.

Recommendation 2. We recommended that the VISN Director ensure that the System Director ensures that a policy is developed regarding the copying and pasting of text in the electronic medical record and that a process to monitor copying and pasting in the electronic medical record is implemented.

Concur

Target Completion Date: Completed

Policy IM-037 Copying and Pasting of Medical Record Documentation was developed. A process has been implemented to monitor copying and pasting in the electronic medical record. Monitor results are reviewed by the Clinical Informatics Committee.

Recommendation 3. We recommended that the VISN Director ensure that the System Director ensures that all EMS employees receive the required *Clostridium difficile* environmental cleaning and IC training.

Concur

Target Completion Date: Completed

The annual training for all EMS employees does include the required C-difficile environmental cleaning and infection control training. During the CAP survey electronic training records from the LMS system were unable to be retrieved. There were no hard copies of the training available. EMS

leadership has implemented an education tracking system through their staff meeting minutes.

Recommendation 4. We recommended that the VISN Director ensure that the System Director ensures that the identified EOC issues are addressed and that action plans are implemented.

Concur

Target Completion Date: Completed

Environment of care issues were addressed and action plans have been implemented. High and low cleaning in the MICU was completed September 15, 2008. All EMS staff assigned to the MICU was retrained on the appropriate cleaning methods for this unit. The contractor sealed the door to ensure Level III ICRA was met and maintained. The contractor placed a keypad lock on the construction access door. All utility rooms were checked and all have the locking hardware and the capability to be locked.

Recommendation 5. We recommended that the VISN Director ensure that the System Director ensures that discharge summaries are completed, as required, and that they are consistent with the discharge instructions provided to patients.

Concur

Target Completion Date: Completed

All nursing staff was reminded to consistently complete discharge instructions for each patient. Effective September 1, 2008, to date, a review of post-discharge phone calls revealed that 100% of the time printed discharge instructions were reviewed and given to the patient. Timely completion of medical records is used in provider-specific data for re-privileging information. The clinical pertinence review tool has been revised to include a review of discharge summaries in correlation with discharge instructions for consistency of information.

Recommendation 6. We recommended that the VISN Director ensure that the System Director establishes a policy to resolve the conflict between the electronic medical record template and the policy concerning PRN pain assessment and documentation.

Concur

Target Completion Date: Completed

The pain assessment template was revised. The section in the template which stated "pain intensity post one hour intervention" was changed to "pain intensity post intervention is:". The registered nurse would specifically document the numerical pain score, date, and time. The change to this template has been reviewed with all nursing staff. No change was made to the policy because the template change resolved the conflict.

Recommendation 7. We recommended that the VISN Director ensure that the System Director revises the current BCMA policy to reflect the current practice.

Concur

Target Completion Date: Completed

Policy TX-009 Use of Omnicell Dispensing System has been revised to reflect the current practice in resolving omnicell discrepancies. The following statement: "any outstanding unresolved discrepancy on the weekly report generated by Pharmacy for the Nurse Managers will be addressed at that time for resolution" has been added to the procedure section of TX-009.

Recommendation 8. We recommended that the VISN Director ensure that the System Director ensures that all inter-facility transfer documentation complies with VHA policy.

Concur

Target Completion Date: Completed

The Emergency Department (ED) Medical Director has reviewed the requirement with all ED providers to complete the Transfer Note Template in CPRS for all patients who are transferred from the ED to another facility. This review will also be incorporated into the orientation for all new ED providers. Compliance is being monitored by the ED Medical Director.

Recommendation 9. We recommended that the VISN Director ensure that the System Director ensures that critical equipment monitoring is performed and documented, as required by system policy.

Concur

Target Completion Date: Completed

The responsibility to check all defibrillators daily was reviewed with all ED registered nurse staff. Defibrillator checklists from September 1, 2008, to date have been appropriately completed.

Recommendation 10. We recommended that the VISN Director ensure that the System Director ensures that all nursing staff point-of-care competency certification documentation is complete.

Concur

Target Completion Date: Completed

Effective October 24, 2008, all ED nursing staff who perform point of care (POC) testing have completed POC competency validation training as of October 24, 2008. Records have been updated and are available in the Critical Care Education Office.

OIG Contact and Staff Acknowledgments

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Report Distribution

VA Distribution

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