



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

Office of Healthcare Inspections

Report No. 08-01332-76

Combined Assessment Program Review of the Birmingham VA Medical Center Birmingham, Alabama



February 25, 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 Birmingham VA Medical Center (the medical center), Birmingham, AL. 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 83 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 7.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in five of the activities reviewed and had one repeat QM finding from the prior CAP review. For these activities, the medical center needed to:

- Require timely completion of peer reviews.
- Require submission of quarterly reports of peer review activities and outcomes to the Health Systems Committee (HSC).
- Require that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with Veterans Health Administration (VHA) policy.
- Require that the Patient Safety Improvement Committee (PSIC) formally meet and provide an annual report of patient safety trends to senior management.
- Ensure that all controlled substances inspectors (CSIs) have current training and certification documentation, as required by medical center policy.
- Ensure that all controlled substances discrepancies are reported within the timeframe outlined in medical center policy.
- Ensure that the physical environment defect identified in the pharmacy clean room is repaired.
- Require medical and nursing staff to complete patient transfer and admission documentation, as required by VHA policy.
- Ensure that infection control (IC) procedures are enforced when medications are administered to patients on isolation precautions.

- Ensure that appropriate emergency department (ED) nurses' annual competency assessments include the skills to perform low-volume but high-risk duties and seldom used but high-risk medications and equipment.
- Ensure that provider-specific intubation and airway management data are included in the re-privileging process, as required by medical center policy.

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

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

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–21, 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 medical center is a tertiary care teaching facility located in Birmingham, AL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics in Oxford, Jasper, Bessemer, Huntsville, Madison, Sheffield, and Gadsden, AL. The medical center is part of VISN 7 and serves a veteran population of about 225,000 throughout 24 counties in Alabama.

Programs. The medical center provides comprehensive health care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics. It specializes in palliative care and multiple sclerosis. The medical center has 144 hospital beds.

Affiliations and Research. The medical center is affiliated with 82 college and university programs. It provides training for 130 medical residents as well as training for students in other health disciplines. In fiscal year (FY) 2007, the medical center research program had 92 projects and a budget of \$4.9 million. Important areas of research included cardiovascular diseases, hepatopulmonary and kidney disorders, brain tumors, and diabetes.

Resources. In FY 2007, medical care expenditures totaled \$213 million. The FY 2008 medical care budget was \$288.5 million. FY 2008 staffing was 1,550 full-time employee equivalents (FTE), including 119.2 physician and 429.9 nursing FTE.

Workload. In FY 2007, the medical center treated 51,205 unique patients and provided 32,634 inpatient days in the hospital. The inpatient care workload totaled 4,624 discharges, and the average daily census was 89.1. Outpatient workload totaled 470,053 visits. FY 2008 data was not available at the time of this report.

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 Controlled Substances Inspections.
- QM.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through September 12, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Birmingham, Alabama*, Report No. 05-02925-144, May 15, 2006). The medical center had not corrected the findings related to peer review activities from our prior CAP review; therefore, we reissued a recommendation in that area.

During this review, we also presented fraud and integrity awareness briefings to 83 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 findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. We interviewed the medical center’s senior management team and QM personnel. We reviewed plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center’s quality of care, and senior managers supported the program. Appropriate review structures were in place for 12 of the 15 program activities evaluated. However, we identified three areas that needed improvement.

Peer Review. The medical center’s peer review process did not comply with certain aspects of VHA policy.¹ Peer review is a confidential, non-punitive, systematic process to evaluate quality of care at the individual provider level. We evaluated peer review activities conducted from June 2007 through June 2008 and identified the following issues:

- The medical center did not complete peer reviews within the required timeframes. We noted that only 118 (69 percent) of 171 peer reviews met the initial

¹ VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

45-day deadline and that only 114 (67 percent) of 171 peer reviews met the 120-day completion deadline. Peer review timeliness was a repeat finding from our prior CAP review.

- The medical center's Peer Review Committee (PRC) did not submit any quarterly reports to the HSC. The HSC has oversight responsibility for peer review activities and outcomes.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. Peer reviews and data evaluation should be conducted in accordance with policy to ensure that providers perform according to accepted community standards and that improvement actions are taken when indicated.

Adverse Event Disclosure. The medical center did not comply with VHA policy.² Clinical disclosure is an informal process to discuss harmful or potentially harmful adverse events with patients and/or their families. Institutional disclosure is a more formal process used in cases of serious injury, death, or potential legal liability and includes an apology, compensation information, and procedures available to request compensation.

We reviewed QM documents and found 15 adverse drug events that required clinical disclosure to the patient or a family member and six other types of events that required clinical or institutional disclosure; however, none of the events had been disclosed or even evaluated for disclosure. Without an effective process to evaluate events that could potentially require disclosure, managers could not be assured that patients received important medical and legal information needed to make decisions.

Patient Safety. The PSIC did not meet regularly with medical center management to review findings from the patient safety/risk management program, as required by medical center policy. In addition, the PSIC did not submit an annual report to the HSC that included an analysis of trends, as required. As a result, opportunities to improve patient safety may have been missed.

² VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews.

The VISN and Medical Center Directors agreed with the findings and recommendation. In April 2008, the PRC was restructured. Since then, all peer reviews have been completed within the required timeframes. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires submission of quarterly reports of peer review activities and outcomes to the HSC, as required by VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation. The first report was submitted to the HSC on December 11, 2008. Quarterly trending reports will continue to be submitted to the HSC. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center's disclosure policy is being revised to restructure the disclosure process, and the Risk Manager was designated to coordinate clinical and institutional disclosure in collaboration with the medical staff. The action plans are acceptable, and we will follow up until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the PSIC formally meet on a regular basis and provide an annual report of patient safety trends to the HSC.

The VISN and Medical Center Directors agreed with the findings and recommendation. PSIC membership has been identified, and a charter for the committee has been written and is in the process of being approved. The committee will

meet on a monthly basis. The action plans are acceptable, and we will follow up until they are completed.

**Pharmacy
Operations and
Controlled
Substances
Inspections**

The purposes of this review were to evaluate the pharmacies' internal physical environments and to determine whether the medical center had adequate controls to ensure the security and proper management of controlled substances. We also evaluated whether clinical managers had processes in place to monitor patients who were prescribed multiple medications.

We reviewed VHA regulations governing pharmacy and controlled substances security, and we assessed whether the medical center's policies and practices were consistent with these regulations. We inspected the inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service, Engineering Service, and Police and Security Service personnel as necessary.

Our review showed that the medical center had appropriate policies and procedures to ensure the security of the pharmacy. Managers reported controlled substances diversions or suspected diversions to the OIG. The pharmacies' internal physical environments were generally secure, clean, and well maintained.

Our review also showed that clinical pharmacists appropriately identified patients who were prescribed multiple medications. 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 an increased risk of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions. We found that the medical center's clinical pharmacists routinely assessed patients for polypharmacy in accordance with guidelines.

We identified three conditions that required management attention.

Controlled Substances Inspectors' Training and Certifications. Controlled substances inspections were conducted in accordance with VHA regulations. However, managers could not provide documentation that 6 (17 percent) of the 36 CSIs had completed the necessary certification in the past year. Also, two CSIs did not have relevant training records on file. Proper documentation of CSI certification and training improves the credibility of the controlled substances inspection process. Staff completed all CSI training and certifications while we were onsite.

Controlled Substances Discrepancy Reporting. Controlled substances discrepancies were generally reported to appropriate managers and to medical center police within the timeframe dictated by medical center policy. However, two discrepancies in narcotic administration and wastage that occurred on February 23 and 24, 2008, were discovered during a routine controlled substances inspection in March 2008 but were not reported to medical center police for more than 6 weeks. A notification of the events was sent to the designated controlled substances supervising officer on March 25, but the police were not notified until May 8, which substantially exceeded the medical center's policy to report suspicious losses or discrepancies within 5 working days.

Infection Control. VHA regulations³ require that a low to medium risk negative pressure clean room⁴ have walls, floors, and ceilings that are smooth and free of cracks and crevices. We found that an access door in the ceiling of the clean room was warped, causing a gap along the seam. This gap could adversely affect the negative pressure and cause contamination of medications being prepared under sterile conditions. While we were onsite, the opening of the access door was temporarily sealed, and a new door was ordered.

Recommendation 5

We recommended that the VISN Director ensure that the Medical Center Director develops a system to assure that all CSIs have current training and certification documentation, as required by medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. All inspectors have

³ VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.

⁴ A room designed specifically for preparation of sterile medications and intravenous products.

completed training and have certificates on file, as required by medical center policy. Controlled Substances Coordinators will follow up to ensure that ongoing training requirements are met and that appropriate documentation is filed each year. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 6

We recommended that the VISN Director ensure that the Medical Center Director requires that all controlled substances discrepancies are reported within the timeframe specified in medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center policy regarding controlled substances discrepancies has been updated. Pharmacy Service and Police and Security Service staff received training on reporting discrepancies. The action plans are acceptable, and we will follow up until they are completed.

Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director requires that the physical environment defect identified in the clean room is repaired.

The VISN and Medical Center Directors agreed with the finding and recommendation. The defect was repaired on December 14, 2008. The corrective action is acceptable, and we consider this recommendation closed.

Coordination of Care

The purposes of this review were to evaluate whether inpatient consultations, admissions and inter-facility transfers via the ED, intra-facility (unit-to-unit) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and Joint Commission (JC) requirements. Coordinated consultations, transfers, and discharges are essential to achieve optimal patient outcomes.

We reviewed the medical records of 17 inpatients and found that consultative services were received and completed within acceptable timeframes. Also, we reviewed the medical records of 15 recently discharged patients and found consistent documentation of patient discharge orders, medications, and instructions. However, we identified two areas that needed improvement.

Intra-Facility Transfers. We found that 5 (38 percent) of 13 medical records of patients transferred between the acute inpatient units did not contain adequate transfer documentation by the sending physician, as required by VHA policy.⁵ Transfer documentation assists the receiving physician in implementing an appropriate plan of care.

Emergency Department Admissions and Inter-Facility Transfers. We reviewed the medical records of five patients who were admitted from the ED to units within the medical center and three patients who were transferred from the ED to other hospitals. None of the medical records of the five patients admitted to the medical center contained consistent documentation of nurse-to-nurse or physician-to-physician communication. We also found that documentation of patient information required by VHA policy⁶ for inter-facility transfers was not being completed on the appropriate form.

Recommendation 8

We recommended that the VISN Director ensure that the Medical Center Director requires medical and nursing staff to complete patient transfer and admission documentation, as required by VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center is developing an electronic transfer form to replace the paper form. ED transfer and admission documentation will be monitored. The action plans are acceptable, and we will follow up 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, a hospice unit, a medical intensive care unit (MICU), a surgical intensive care unit (SICU), and a coronary care unit (CCU). Also, we reviewed 29 medical records and noted that effectiveness of pain medication was assessed and documented, as required by medical center policy.

We found adequate management of medications brought into the medical center by patients or their families and

⁵ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

⁶ VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

appropriate use of patient armbands to correctly identify patients prior to medication administration. However, we identified one area that needed improvement.

Isolation Procedures. We observed an incident where a barcode scanner⁷ was taken into an isolation room. Medical center policy states that in the case of isolation, the barcode scanner should not be taken into the patient's room due to IC concerns. Rather, a duplicate patient identification band is to be placed in the top drawer of the isolation cart outside of the room.

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires that IC procedures be enforced when administering medications to patients on isolation precautions.

The VISN and Medical Center Directors agreed with the finding and recommendation. A medical center review determined that the current practice was acceptable if the barcode scanner was cleaned with germicidal cloths after each use in an isolation room. Medical center policy is being revised to be consistent with practice. The action plans are acceptable, and we will follow up until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether medical center EDs complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED and triage environments for cleanliness and safety.

The ED is open 24 hours per day, 7 days per week, as required for an ED. It is located within the main hospital building, and emergency services provided are within the medical center's patient care capabilities. In addition, the medical center has an appropriate policy for managing patients whose care may exceed the medical center's capabilities and has Memorandums of Understanding with local private facilities.

We found the ED to be generally clean and safe, and patients with acute mental health needs were assigned to appropriate ED rooms deemed safe for this population. We

⁷ A device used to scan the barcodes on medications and patient identification bracelets to assure that patients receive the correct medications.

reviewed the ED nurse staffing plan, patient flow data, and work schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. However, we identified the following areas that needed improvement.

Emergency Department Staff Competency. We found that ED nursing staff competency assessments did not include pediatric and obstetric emergency equipment and medications as part of the skill set. Because the ED is equipped with emergency obstetric and pediatric equipment and medications, appropriate ED nursing staff must be evaluated annually to ensure that they maintain the necessary skills to perform the low-volume but high-risk duties associated with these types of patients.

Clinical Privileges. We found that physicians' delineated clinical privileges were current, clearly defined, and readily available to the ED staff for reference. However, we found no provider-specific data analysis or evidence of periodic review for re-privileging in intubation and airway management, as required by medical center policy.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director requires that appropriate ED nurses' annual competency assessments include the skills to perform low-volume but high-risk duties and seldom used but high-risk medications and equipment.

The VISN and Medical Center Directors agreed with the finding and recommendation. ED annual nurse competency assessments will be modified. Pediatric equipment, supplies, and medications have been removed from the ED, and only emergency basic life support resuscitation will be performed on neonatal and pediatric patients to stabilize them for transport to an appropriate facility. The action plans are acceptable, and we will follow up until they are completed.

Recommendation 11

We recommended that the VISN Director ensure that the Medical Center Director requires that provider-specific intubation and airway management data are included in the re-privileging process, as required by medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Credentialing and Privileging office will receive provider-specific information

based on resuscitation record analysis from the Cardiopulmonary Resuscitation Subcommittee and provider intubation training records from Anesthesia Service. This information will be furnished to clinical service chiefs for re-privileging. The action plans are acceptable, and we will follow up until they are completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine if VHA medical centers maintain a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and JC standards.

We inspected the acute inpatient medical/surgical units, the MICU, the SICU, the CCU, the ED, the palliative care and dialysis units, and the primary care clinics. We found that the medical center was generally clean and well maintained and had corrected the EOC findings from our prior CAP review. The IC program monitored exposures and reported data to clinicians for implementation of quality improvements.

During environmental rounds, we found dust in air ventilation outlets on several inpatient units. We were told by managers that the outlets were cleaned annually. Controlling dust emissions reduces patient risk for dust-related respiratory problems. While we were onsite, managers provided an action plan to ensure quarterly scheduled cleaning of air ventilation outlets. Therefore, we made no recommendations.

Staffing

The purpose of this review was to evaluate whether the medical center had developed comprehensive staffing guidelines and whether the guidelines had been met. We reviewed staffing worksheets for six inpatient units for nine different shifts. The medical center had developed guidelines for staffing by patient classification and acuity using the Automated Management Information System (AMIS). We found that the medical center's guidelines for nurse staffing were met on the units reviewed and that specific actions had been taken to ensure safe patient care, including the use of intermittent nurses, overtime, and sharing of staff between units.

Although AMIS was not accurate as a staffing methodology in the critical care units and the ED due to the limitations of

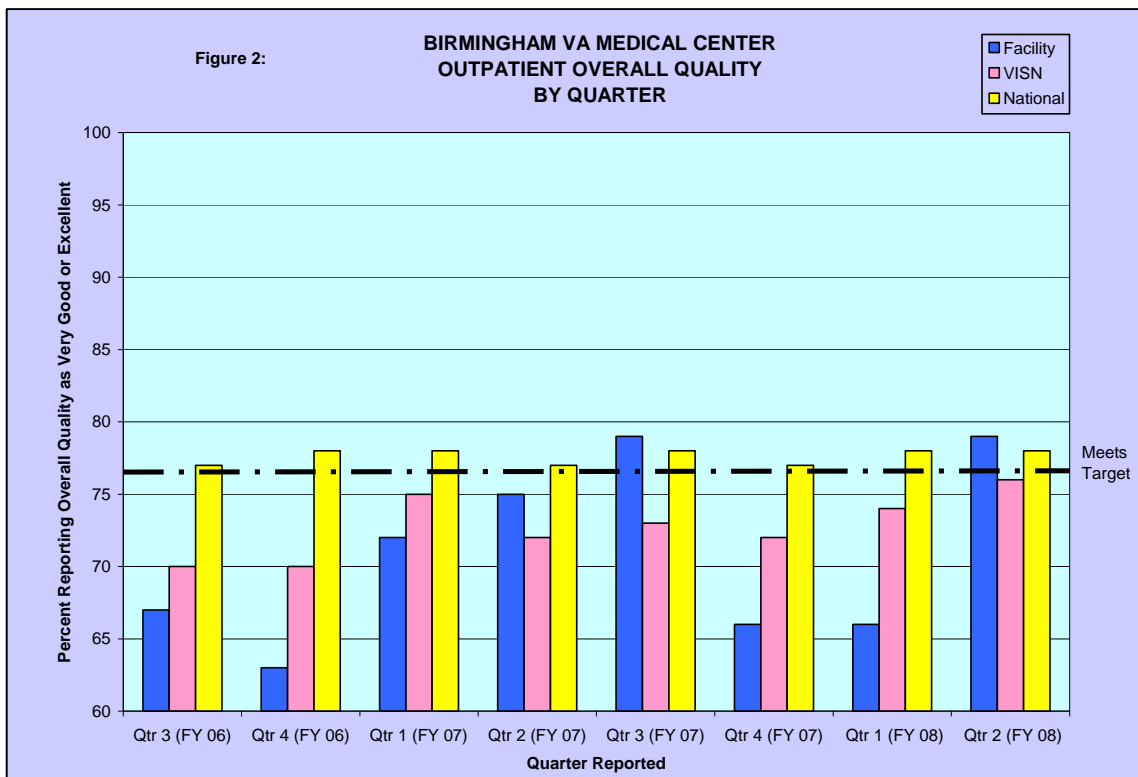
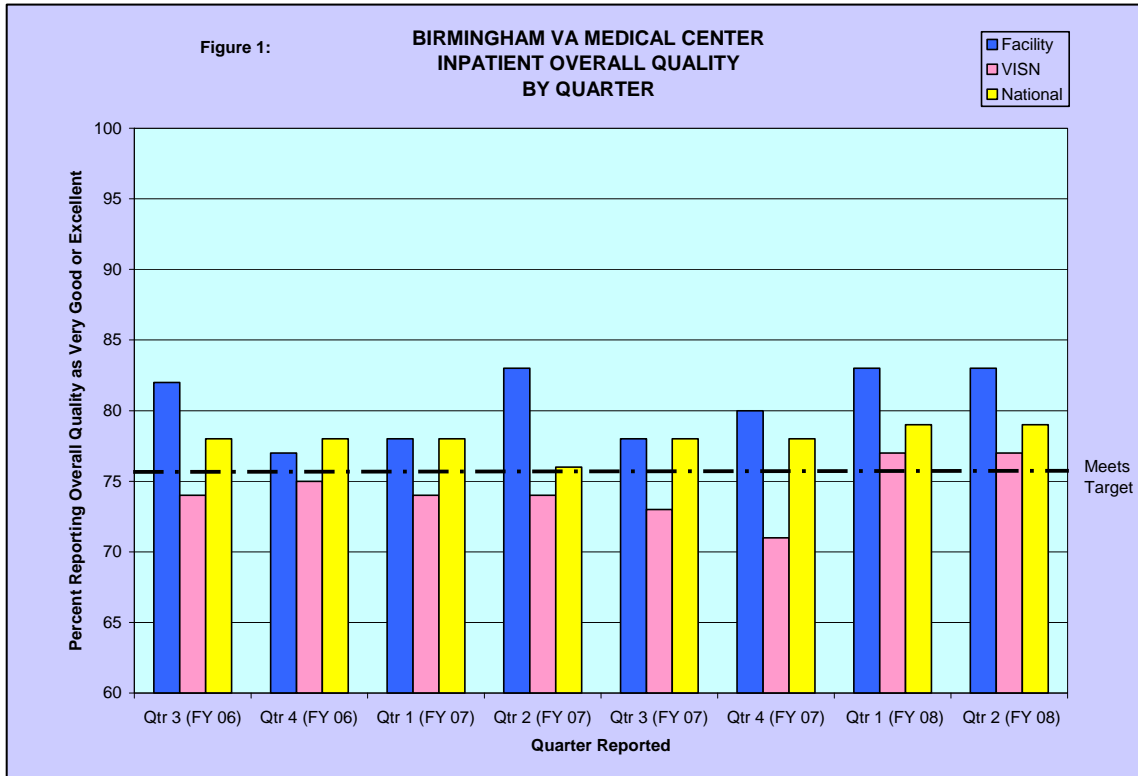
the system, we found that the medical center had additional staffing plans in these areas that provided for safe patient care. We were told that AMIS is a VA-wide program that is being redesigned. Since the actual staffing worksheets demonstrated adequate staff to meet patient care needs, we made no recommendations.

**Survey of
Healthcare
Experiences of
Patients**

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

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

Figures 1 and 2 on the next page show the medical center's patient satisfaction performance measure results for inpatients and outpatients, respectively.



For inpatient overall quality, the medical center met or exceeded the established target for all of the last 8 quarters of available data. For outpatient overall quality, the medical center only met the established target for 2 of the last 8 quarters of available data. The medical center had a multidisciplinary Customer Service Committee that analyzed and reported SHEP survey results. Managers had developed specific action plans to improve outpatient services and had implemented those plans in multiple clinics and outpatient areas. Review of the plan, actions taken, and recent internal patient satisfaction scores demonstrated positive impact; therefore, we made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 18, 2008

From: Director, VA Southeast Network (10N7)

Subject: Combined Assessment Program Review of the Birmingham
VA Medical Center, Birmingham, Alabama

To: Associate Director, St. Petersburg Office of Healthcare
Inspections (54SP)

Director, Management Review Service (10B5)

I concur with the recommendations and planned actions.

(original signed by:)

Lawrence A. Biro

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 17, 2008
From: Director, Birmingham VA Medical Center (521/00)
Subject: Combined Assessment Program Review of the Birmingham VA Medical Center, Birmingham, Alabama
To: Director, VA Southeast Network (10N7)

I concur with the findings/recommendations presented in the Birmingham VA Medical Center OIG CAP review. Actions taken as a result of these findings can be found beginning on the following page.

(original signed by:)

Rica Lewis-Payton, MHA, FACHE

Comments to Office of Inspector General's Report

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews.

Concur

In April 2008, the Peer Review Subcommittee was restructured and each case is entered into a database to facilitate tracking of case review to ensure timely completion of peer reviews. Since April 2008, all peer reviews have been timely both with the 45-day initial review and the 120-day case completion timeframes.

Target Date: Completed. Changes implemented April 1, 2008. Tracking has demonstrated performance to be 100% in regard to timely completion of peer reviews for 3rd and 4th Quarter 2008.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires submission of quarterly reports of peer review activities and outcomes to the HSC, as required by VHA policy.

Concur

The first report was submitted to the Health Systems Committee (HSC) on December 11, 2008, and will continue to submit quarterly summaries to HSC showing trending.

Target Date: Ongoing.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.

Concur

The facility Disclosure Policy is being revised to restructure the disclosure process. The facility Risk Manager was designated as the point person to coordinate clinical and institutional disclosure in coordination with the medical staff.

Target Date: January 15, 2009.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the PSIC formally meet on a regular basis and provide an annual report of patient safety trends to the HSC.

Concur

The facility Patient Safety Committee membership has been identified, and a charter for the committee has been written and is in the approval process. The Patient Safety Committee will meet on a monthly basis with the first meeting scheduled for January 14, 2009. The 2008 annual report of patient safety trends as required by the directive has been completed and forwarded to the HSC.

Target Date: January 31, 2009.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director develops a system to assure that all CSIs have current training and certification documentation, as required by medical center policy.

Concur

All inspectors have completed training and were given certificates as required by medical center policy. Controlled Substances Coordinators will follow up to ensure that training is complete and that appropriate documentation is provided and filed before the end of 3rd quarter each year. The training requirements and certificates of the five CSIs which were initially identified by the IG reviewers as missing were provided to the IG reviewers by the end of the survey. All CSIs are now current with training and have certificates on file.

Target Date: Completed September 12, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all controlled substances discrepancies are reported within the timeframe specified in medical center policy.

Concur

The medical center policy regarding controlled substances discrepancies has been updated and is pending final approval. On September 15, 2008, Pharmacy and Police were educated by Controlled Substances Coordinators to report discrepancies to the CSCs within the specified timeframes outlined in medical center policy.

Target Date: January 31, 2009, for final policy approval.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that the physical environment defect identified in the clean room is repaired.

Concur

Completed. The new access panel was received and installed in the clean room on December 14, 2008.

Target Date: Completed December 14, 2008.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires medical and nursing staff to complete patient transfer and admission documentation, as required by VHA policy.

Concur

The facility is working with Information Technology to develop an electronic transfer form to replace the paper form. The presence of Emergency Department admission and transfer documents will be monitored through tracer visits performed by Quality Resource staff as part of JC readiness and ongoing medical record monitoring performed by the Medical Record Subcommittee.

Target Date: Ongoing.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that IC procedures be enforced when administering medications to patients on isolation precautions.

Concur

The facility practice did not meet policy. On December 11, 2008, the chairman of the facility Infection Control Subcommittee and the Infection Control nurse reviewed current practice of carrying the medication scanners into an isolation room for barcode scanning and determined the practice was acceptable and meeting infection control standards if the scanner was wiped-down with germicidal cloths each time the scanner was taken out of an isolation room. Facility policy is currently being revised to match policy with practice.

Target Date: January 31, 2009.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that appropriate ED nurses' annual competency assessments include the skills to perform low-volume

but high-risk duties and seldom used but high-risk medications and equipment.

Concur

Emergency Department annual nurse competency assessments will be modified to include skills, medications, and equipment that may be seldom used but have a high potential for causing patient harm. Only emergency BLS resuscitation will be performed on neonatal and pediatric patients for stabilization and then transported to a local medical center for continued appropriate care. Pediatric equipment, supplies, and medications have been removed from the Emergency Department.

Target Date: January 31, 2009.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that provider-specific intubation and airway management data are included in the re-privileging process, as required by medical center policy.

Concur

The CPR subcommittee will submit provider-specific information via Code analysis reports and Anesthesia Service will submit provider intubation training records to the Credentialing and Privileging office so information can be furnished to clinical service chiefs for re-privileging.

Target Date: January 31, 2009.

OIG Contact and Staff Acknowledgments

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Report Distribution

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