Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01334-261

Combined Assessment Program Review of the Erie VA Medical Center Erie, Pennsylvania

September 4, 2012

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 crime awareness briefings 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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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Erie VA Medical Center
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Erie VA Medical Center, Erie, PA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 7, 2012.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Environment of Care
- Medication Management
- Nurse Staffing

The facility's reported accomplishments were recognition by the Commission on Accreditation of Rehabilitation Facilities for collaboration with community resources and recognition by The Joint Commission for high achievement on surgical accountability measures.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure that the Peer Review Committee is consistently notified when corrective actions are completed and that ethics consultations are documented in electronic health records.

Polytrauma: Ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care.

Colorectal Cancer Screening: Ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Point-of-Care Testing: Ensure staff complete the actions required in response to critical test results.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- CRC Screening
- EOC
- Medication Management
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through May 10, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania,* Report No. 10-01782-222, August 16, 2010).

During this review, we presented crime awareness briefings for 141 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 122 responded. We shared survey results with facility managers.

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.

Reported Accomplishments

Commission on Accreditation of Rehabilitation Facilities Recognition

The facility was recognized for exemplary conformance to the Commission on Accreditation of Rehabilitation Facilities' standards for collaboration with community resources to provide choices for veterans served and augment the array of services provided at the facility.

Joint Commission Recognition

The facility was listed as a top performer in "Improving America's Hospitals – The Joint Commission's Annual Report on Quality and Safety 2011" for achieving a composite compliance score and performance target of at least 95 percent for all surgical care accountability measures reported.

Results
Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
X	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Peer Review. VHA requires that the Peer Review Committee receive written notification upon completion of corrective actions.[1] We reviewed meeting minutes for the period of March 2011–May 2012 and identified 11 corrective actions that should have been completed. There was no evidence that four of these completed corrective actions were reported to the committee.

Integrated Ethics. VHA requires that final summary notes for ethics consultations pertaining to active clinical cases are entered into EHRs.[2] We reviewed five ethics consultations and found that two were not documented in the EHRs.

Recommendations

1. We recommended that processes be strengthened to ensure that the Peer Review Committee is consistently notified when corrective actions are completed.

2. We recommended that processes be strengthened to ensure that ethics consultations are documented in the EHRs.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 20 EHRs of patients with positive traumatic brain injury results, and training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that a specific interdisciplinary treatment plan be developed for each polytrauma outpatient who needs interdisciplinary care.[3] Three of the 10 polytrauma outpatient EHRs we reviewed did not have the required treatment plans.

Recommendation

3. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care.

[3] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[4] Four of the 15 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Recommendation

4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to confirm results with a repeat test, initiate appropriate treatment, and notify the clinician. The employee must then document clinician notification, critical results, and treatment in the EHR. For 2 of the 10 patients who had critical test results, there was no documented evidence of clinician notification.

Recommendation

5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 21 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected four inpatient units (intensive care, medical/surgical, palliative care, and CLC), the emergency department, the physical medicine and rehabilitation medicine departments, and five outpatient clinics (dental, podiatry, polytrauma, primary care, and SCI). Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Access points had keyless entry and closed circuit television monitoring.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[5] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[5] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 13 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (6) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[6]		
Type of Organization	General medical/surgical medical center	
Complexity Level	3	
VISN	4	
Community Based Outpatient Clinics	Ashtabula, OH (Ashtabula County) Meadville, PA (Crawford County) Franklin, PA (Venango County) Bradford, PA (McKean County) Warren, PA (Warren County)	
Veteran Population in Catchment Area	63,405	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	26	
• **CLC/Nursing Home Care Unit**	52 beds with 13 beds out of service	
• **Other**	NA	
Medical School Affiliations	Lake Erie College of Osteopathic Medicine	
• **Number of Residents**	36	
	Current FY (through January 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$119.9	$123.2
• **Medical Care Expenditures**	$39.5	$122.7
Total Medical Care Full-Time Employee Equivalents	659.6	661.1
Workload:		
• **Number of Station Level Unique Patients**	16,581	22,745
• **Inpatient Days of Care:**		
o **Acute Care**	1,009 plus 171 observation	3,085 plus 438 observation
o **CLC/Nursing Home Care Unit**	4,404	12,893
Hospital Discharges	337 plus 53 CLC	1,066 plus 187 CLC
Total Average Daily Census (including all bed types)	44	44
Cumulative Occupancy Rate (in percent)	32 92 CLC	33 91 CLC
Outpatient Visits	90,153	254,720

[6] All data provided by facility management.

VHA Satisfaction Surveys

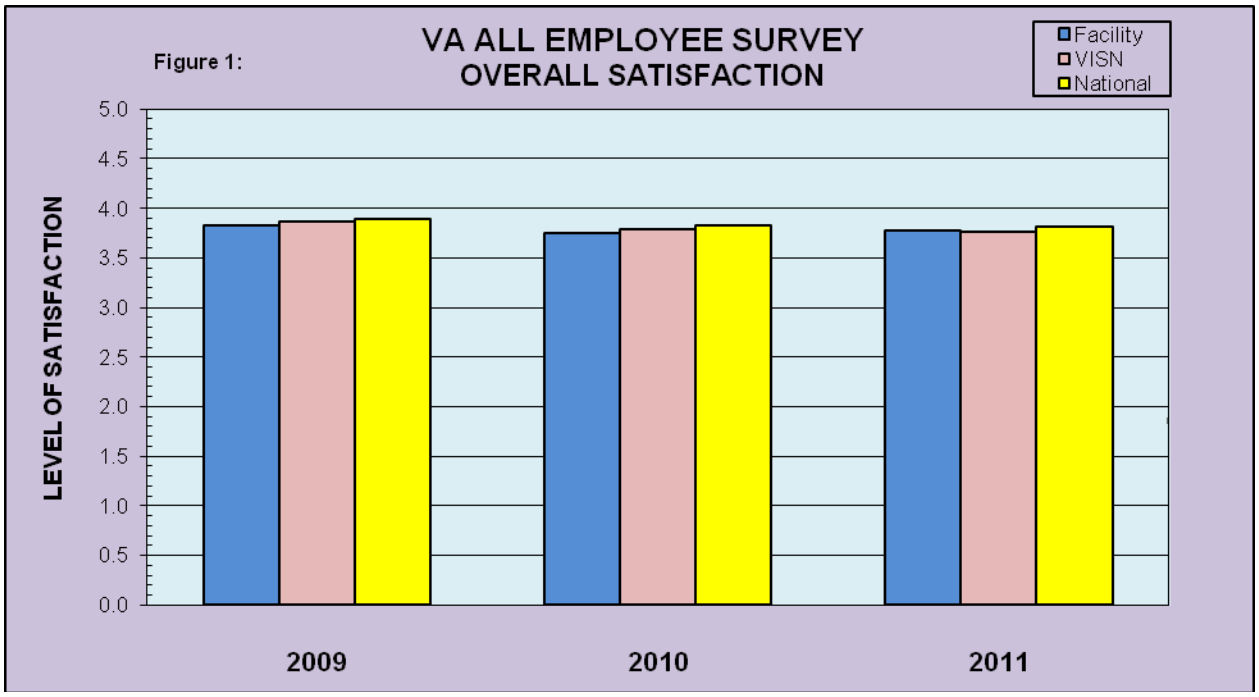
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 2011 and quarter 1 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011		FY 2011			FY 2012
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1
Facility	74.6	81.0	70.2	70.9	68.1	69.1
VISN	63.6	67.4	59.2	61.1	61.6	59.5
VHA	63.9	64.1	55.3	54.2	54.5	55.0

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[7] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[8]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.3	11.7	9.8	19.6	24.7	16.3
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[7] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[8] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 17, 2012

From: Director, VA Healthcare (10N4)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed the draft report of the Erie VA Medical Center. I concur with the findings and implemented plans.

(original signed by:)
MICHAEL A. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 16, 2012

From: Director, Erie VA Medical Center (562/00)

Subject: **CAP Review of the Erie VA Medical Center, Erie, PA**

To: Director, VA Healthcare (10N4)

I have reviewed the draft report of the Inspector General Combined Assessment Program Review of the Erie VA Medical Center. I concur with the findings outlined in this report and have included corrective action plans for each recommendation.

(original signed by:)
MICHAEL D. ADELMAN, MD

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the Peer Review Committee is consistently notified when corrective actions are completed.

Concur

Target date for completion: Complete

A status update column was added to the Action Plan template for the Peer Review Committee (PRC) to track receipt of completed corrective actions. This template is used to ensure that all actions are completed and corrective actions are sustained. The Action Plan template was approved by the PRC and implemented on April 25, 2012. The PRC actions are assigned to responsible staff/departments via a memo, due dates are assigned and the time line for status updates is tracked monthly by the PRC support staff in the PRC minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that ethics consultations are documented in the EHRs.

Concur

Target date for completion: October 31, 2012

The Ethics Consultation (EC) Coordinator established a process to ensure that the EC Web consult summary page is entered into the electronic health record under the Ethics Note Title at the time each ethics consult is completed. This process was approved by the Ethics Committee on 6/7/2012 and implemented on 6/7/2012. The EC Web Evaluator will perform ongoing monitoring to ensure that the EC Web ethics consult summary page is entered into the electronic health record.

Recommendation 3. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care.

Concur

Target date for completion: October 31, 2012

The Rehabilitation Supervisor reviewed the roles and criteria that require an Interdisciplinary Care Team (IDT) care plan with the OEF/OIF Case Manager on

4/12/2012 to ensure they understood that an IDT care plan was needed for all OEF/OIF Veterans in the Polytrauma Support program. An Excel spreadsheet was created on 4/12/2012 to track the Polytrauma cases to ensure that periodic reviews and discharge planning are completed. The note title for the Nurse Practitioner consults was changed to "Polytrauma Support Outpatient Consult" on 4/17/2012. This was done to eliminate confusion and inappropriate use of the "TBI/Polytrauma Plan of Care" note title. A weekly IDT conference was started in May. The IDT plan of care notes are completed during the conference. The "Polytrauma TBI" clinic will be separated into "Polytrauma" and "TBI" clinics in August. This will make it easier to evaluate the effectiveness of the actions taken. A monitor will be added to the Chief of Staff Performance Improvement Scorecard with a goal of 100% for completion of the "Polytrauma Support Team Consult" and "TBI/Polytrauma Plan of Care" notes for all OEF/OIF Polytrauma cases.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Complete

The Chief of Surgery reviewed the requirements for documentation of diagnostic test results as outlined in VHA Directive 2007-004, MCM 111-39 (Ordering and Reporting Test Results), MCM 111-28 (Patient Notification of Critical Test Results) and MCM 111-07 (Colorectal Cancer Screening and Follow-up) with the provider on 5/10/2012. During a review of 51 electronic health records from 3/18/2012 through 6/29/2012, 50 records (98%) had documentation of patient notification of test results within 14 days. Monitoring will continue to ensure compliance is sustained.

Recommendation 5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Concur

Target date for completion: October 31, 2012

The Clinical Application Coordinator is developing a note template for documentation of action taken in response to critical blood glucose values from finger stick testing by 7/20/2012. The note will include: name of provider receiving and reading back the critical result, name of nursing staff notifying the provider, date/time of notification and treatment necessary. The Nursing Unit Supervisors and the Ancillary Testing Coordinator will educate the nursing staff on this documentation process by 8/31/2012. Critical finger stick glucose results will be reviewed daily for accompanying note and outliers will be provided to the Nursing Supervisor for follow-up action. The Nursing Supervisor will report the monitoring results monthly on the Nurse Executive Performance Improvement Scorecard.

OIG Contact and Staff Acknowledgments

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