Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01295-232

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

July 21, 2011

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

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
DBC	Disruptive Behavior Committee
EN	enteral nutrition
EOC	environment of care
facility	Birmingham VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HSC	Health Systems Council
IC	infection control
OIG	Office of Inspector General
OR	operating room
OSHA	Occupational Safety and Health Administration
PR	peer review
PRC	Peer Review Committee
QM	quality management
RN	registered nurse
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Birmingham VA Medical Center, Birmingham, AL

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management (QM), and to provide crime awareness training. We conducted the review the week of May 9, 2011.

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

- Enteral Nutrition Safety
- Medication Management
- Registered Nurse Competencies

The facility's reported accomplishments were the Operating Room (OR) Systems Redesign project that increased the number of OR cases and the Patient Orientation Program that helps veterans new to the VA.

Recommendations: We made recommendations in the following five activities:

QM: Ensure that QM data is consistently analyzed and that corrective actions are evaluated for effectiveness. Require that the designated Utilization Management (UM) Ad-Hoc Committee reviews UM data and that the facility approves the case exemptions for Physician UM Advisor review. Ensure that peer review data summaries include all required elements and that the Peer Review Committee monitors closure of issues identified or referred for follow-up to other venues.

Physician Credentialing and Privileging: Ensure that ongoing Focused Professional Practice Evaluation is completed within the defined 12-month period and that monitoring data is maintained in physicians' profiles. Maintain adequate competency data in all physicians' profiles.

Management of Workplace Violence: Ensure all violent incidents involving patients are discussed at the Disruptive Behavior Committee.

Environment of Care: Ensure that annual bloodborne pathogens training and N95 respirator fit testing are completed and that compliance is monitored.

Coordination of Care: Ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

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.

(original signed by:)

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:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through May 9, 2011, 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 facility (*Combined Assessment Program Review of the Birmingham VA Medical Center,*

Birmingham, Alabama, Report No. 08-01332-76, February 25, 2009). (See Appendix B for further details.) The facility had a repeat finding in the emergency/urgent care operations area, which appears under physician C&P.

During this review, we also presented crime awareness briefings for 234 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.

Reported Accomplishments

OR Systems Redesign

In 2008, the facility initiated the OR Systems Redesign project to improve the rate of first case on-time starts and to reduce the rate of surgical case cancellation. Through improved communication, changes in personnel and processes, and input from all OR staff, the facility was able to increase on-time starts to an average of 80 percent and decrease cancellations to an average of 10 percent. Additionally, between FYs 2009 and 2010, the facility was able to increase the number of OR cases by 9 percent. In May 2011, the Deputy Under Secretary for Health for Operations and Management selected the project for the Systems Redesign Champion Award.

Patient Orientation Program

The purpose of the Patient Orientation Program is to help veterans who are new to the VA become more familiar with the facility, staff, and services provided. Orientation is conducted monthly and usually has an average of 35 veterans and family members in attendance. It includes a tour of the facility, and packets with eligibility and benefits, after-hours telephone care, privacy, and prescription refill information are provided.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Data Analysis. VHA requires that each facility aggregate, trend, and analyze data using established goals or benchmarks; identify opportunities for improvement; and evaluate corrective actions for effectiveness.[1] We found that the Cardiopulmonary Resuscitation Committee and the UM Committee did not consistently analyze data or evaluate corrective actions for effectiveness.

UM. VHA requires an interdisciplinary group to review UM data on an ongoing basis and states that facility policy may identify cases which can be exempted from referral to a Physician UM Advisor.[2] We found that the facility did not establish the UM Ad-Hoc Committee until March 2011 and did not have a process for ongoing review of UM data. In addition, the draft of case exemptions for Physician UM Advisor review had only been prepared on May 9, 2011, and had not yet been approved.

PR. VHA requires that quarterly PR data summaries, which include specific elements, are reviewed by a medical executive-level committee and that the PRC have a process to monitor closure of issues identified or referred outside of the PRC for follow-up.[3] We found that quarterly PRC data summaries were provided to the QM Council but did not include the number of deaths screened for PR, the PR levels assigned by initial reviewer, or the number of PR levels changed by the PRC. In addition, we found that the PRC did not have a process for monitoring closure of issues identified or referred for follow-up to other venues.

Recommendations

1. We recommended that processes be strengthened to ensure that QM data is consistently analyzed and that corrective actions are evaluated for effectiveness.

2. We recommended that the designated UM Ad-Hoc Committee reviews UM data and that the facility approves the case exemptions for Physician UM Advisor review.

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.
[3] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

3. We recommended that PR data summaries include all required elements and that the PRC monitor closure of issues identified or referred for follow-up to other venues.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that an FPPE be completed for all newly hired physicians and that monitoring data be maintained in the physicians' profiles.[4] Facility policy defines a 12-month FPPE period. We reviewed the profiles of four newly hired physicians; one physician's FPPE was not due for committee review at the time of our visit. We found that two of the three completed FPPEs were not completed within the defined 12-month period and that the profiles did not contain monitoring data for FPPE.

Ongoing Professional Practice Evaluation. VHA requires that data consistent with service-specific competency criteria be collected and maintained in each physician's profile.[5] None of the six applicable physicians' profiles included in our review contained evidence of data for the previous two 6-month evaluation periods.

Competency Data. VHA requires that competency data be collected and maintained in each physician's profile. We did not find evidence of competency data to support renewal of out-of-OR airway management privileges. This is a repeat finding from the previous CAP review from the emergency/urgent care operations review area.

Recommendations

4. We recommended that ongoing FPPE be completed within the defined 12-month period and that monitoring data be maintained in the physicians' profiles.

5. We recommended that adequate competency data be maintained in all physicians' profiles.

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[5] VHA Handbook 1100.19.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following area that needed improvement.

Management of Incident. Facility policy requires all violent incidents involving patients to be discussed at the DBC. We reviewed DBC meeting minutes and did not find discussion of an incident where a patient assaulted an employee.

Recommendation

6. We recommended that processes be strengthened to ensure that all violent incidents involving patients are discussed at the DBC.

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 the emergency department, primary care (red and blue), dental, 3A (gastrointestinal laboratory), 3K (bronchoscopy), 4 main (surgery), the surgical intensive care unit, 5 main (medicine), blind rehabilitation (4th and 5th floors), palliative care (6th floor), the medical intensive care unit, the cardiac catherization laboratory, same day/ambulatory surgery, and the OR. The facility maintained a generally clean and safe environment.

OSHA requires construction sites to be secured and oxygen tanks to be properly stored. We found the dental construction area door unsecured, and we found large, portable oxygen tanks in an open hallway outside the medical intensive care unit. The facility corrected these items while we were onsite; therefore we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

IC. OSHA requires that employees with occupational exposure risk receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 34 employee training records and found that six employees (18 percent) did not have this training documented.

If facilities use N95 respirators, OSHA requires that designated employees are fit tested annually. We reviewed 38 employee training records and determined that 14 (37 percent) designated employees did not have the required annual fit testing.

Recommendation

7. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and ADs in accordance with applicable requirements.

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following area that needed improvement.

AD Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[6] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that none of the records contained evidence that the patients received notification at the time of the most recent inpatient stay.

Recommendation

8. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We inspected areas where EN products were stored while conducting the EOC review, and

[6] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that a plan was in place to take action if deficiencies were identified. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[7]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	7	
Community Based Outpatient Clinics	Anniston, AL Bessemer, AL Childersburg, AL Decatur, AL Florence, AL Gadsden, AL Guntersville, AL Huntsville, AL Jasper, AL	
Veteran Population in Catchment Area	202,912	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	151	
• **Community Living Center/Nursing Home Care Unit**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	The University of Alabama at Birmingham	
• **Number of Residents**	134	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$351.1	$322.8
• **Medical Care Expenditures**	$152.7	$322.3
Total Medical Care Full-Time Employee Equivalents	1,941	1,841
Workload:		
• **Number of Station Level Unique Patients**	43,882	57,851
• **Inpatient Days of Care:**		
o **Acute Care**	11,735	36,431
o **Community Living Center/Nursing Home Care Unit**	0	0
Hospital Discharges	1,879	5,876
Total Average Daily Census (including all bed types)	112	112
Cumulative Occupancy Rate (in percent)	76	79
Outpatient Visits	345,186	639,847

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Complete PRs timely.	The PR Subcommittee was restructured. A database was developed and has been maintained to show timely PR completion.	Y	N
2. Ensure submission of quarterly reports of PR activities and outcomes to the HSC, as required by VHA policy.	The PRC reports to the QM Council who reports to the HSC. After the CAP, quarterly minutes were submitted to the HSC showing trending and have been maintained.	Y	N
3. Ensure mechanisms are in place to adequately evaluate and disclose adverse events in accordance with VHA policy.	The Disclosure of Adverse Events to Patients policy was revised to restructure the disclosure process.	Y	N
4. Ensure the Patient Safety Improvement Committee formally meets on a regular basis and provides an annual report of patient safety trends to the HSC.	The Patient Safety Committee meets regularly and provides a summary of patient safety trends to the QM Council who reports the information to the HSC.	Y	N
Pharmacy Operations and Controlled Substances Inspections			
5. Develop a system to assure that all controlled substance inspectors have current training and certification documentation, as required by facility policy.	All certificates are on file and current. The system developed uses calendar reminders that prompt Controlled Substance Coordinators to verify that certificates are on file for all active inspectors before the last workday in January each year.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
6. Ensure all controlled substances discrepancies are reported within the timeframe specified in facility policy.	A policy regarding controlled substance discrepancies was modified with a timeframe that allows coordination between multiple parties.	Y	N
7. Ensure the physical environment defect identified in the clean room is repaired.	The new access panel was installed in the clean room in December 2008.	Y	N
Coordination of Care			
8. Require medical and nursing staff to complete patient transfer and admission documentation, as required by VHA policy.	An electronic transfer form was developed to replace the paper form to facilitate completion of admission, inter-ward, and inter-facility transfers. QM monitors compliance.	Y	N
Medication Management			
9. Ensure IC procedures are enforced when administering medications to patients on isolation precautions.	The IC protocol for administering medications when a patient is on isolation precautions was clarified, approved, published, and communicated to staff in September 2010. Routine observations of staff compliance are been made during IC and EOC rounds.	Y	N
Emergency/Urgent Care Operations			
10. Ensure appropriate emergency department 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 emergency department RN position-specific competency checklist was modified to include skills, medications, and equipment that may be seldom used but have a high potential for causing patient harm.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
11. Ensure provider-specific intubation and airway management data are included in the reprivileging process, as required by facility policy.	Each provider (other than anesthesiologists) who request out-of-OR airway management privileges must provide proof of at least three successful intubations. The proof will be either patient notes or supervised intubations.	N	Y (see page 4)

VHA Satisfaction Surveys

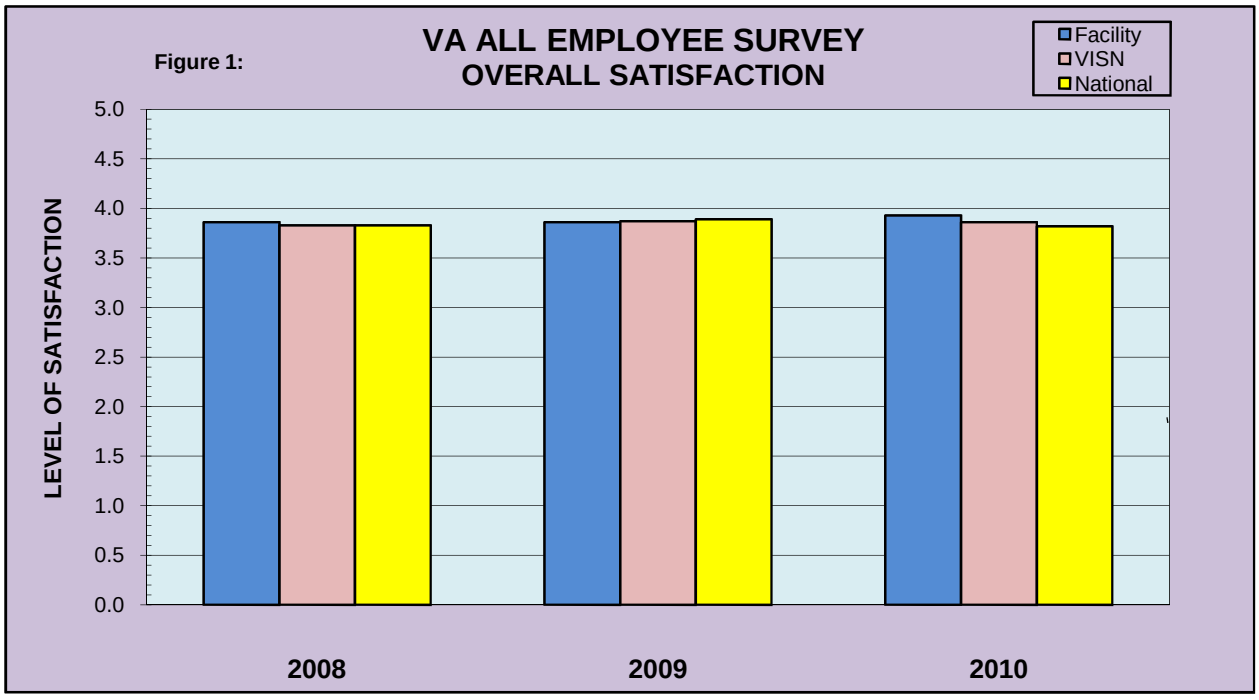
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	69.8	70.0	75.5	77.5	61.5	57.8	56.6	53.2
VISN	67.6	63.8	68.3	64.2	52.7	51.7	52.2	52.1
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. 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[8] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	13.99	11.36	16.54	21.11	19.73	13.43
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[8] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2011

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Birmingham VA Medical Center, Birmingham, AL**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

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 pages.

(original signed by:)

James Clark, MPA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 20, 2011

From: Director, Birmingham VA Medical Center (521/00)

Subject: **CAP Review of the Birmingham VA Medical Center, Birmingham, AL**

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

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 processes be strengthened to ensure that QM data is consistently analyzed and that corrective actions are evaluated for effectiveness.

Concur

Target date for completion: January 1, 2012

A Director for Quality Management was identified to fill the position vacancy and was in her new position effective June 19, 2011. The new Director for Quality Management, in collaboration with all clinical and administrative services, will develop a comprehensive Quality Management program to ensure that QM data is consistently analyzed and corrective actions are evaluated for effectiveness.

Recommendation 2. We recommended that the designated UM Ad-Hoc Committee reviews UM data and that the facility approves the case exemptions for Physician UM Advisor review.

Concur

Target date for completion: Approval of case exemptions for Physician UM Advisor review: Health Systems Council (Medical Executive Board) agenda item: July, 2011

Enhancement of UM Ad-Hoc review of UM data: October 1, 2011

The UM Ad-Hoc Committee was established in March 2011 and will continue to enhance its process for reviewing UM data. The Chief, Business Management Service, will solicit best practices from other VA facilities with more mature UM Committees and utilize these practices as appropriate for this organization's UM Ad-Hoc Committee. The draft of case exemptions for Physician UM Advisor review was prepared on May 9, 2011 and will be processed through appropriate approval process(es).

Recommendation 3. We recommended that PR data summaries include all required elements and that the PRC monitor closure of issues identified or referred for follow-up to other venues.

Concur

Target date for completion: August 1, 2012

A Peer Review Data Summary document will be developed and utilized as a means to report all required elements that to the Health Systems Council (Medical Executive Board). This information will be reported to the Health Systems Council on a quarterly basis. In addition, a tracking system will be developed to monitor the closure of issues identified or referred for follow up to other venues. This information will be reported on a monthly basis to the Peer Review Committee.

Recommendation 4. We recommended that ongoing FPPE be completed within the defined 12-month period and that monitoring data be maintained in the physicians' profiles.

Concur

Target date for completion: Implementation of the new approved FPPE process will be immediate with ongoing review for compliance by Quality Management.

Target date for full implementation: May 31, 2012

A new ongoing FPPE process was established and approved by Health Systems Council (Medical Executive Board) on June 23, 2011.

Recommendation 5. We recommended that adequate competency data be maintained in all physicians' profiles.

Concur

Target date for completion: October 1, 2011

Tools to assist service chiefs and guidelines delineating the process will be developed to ensure Ongoing Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE) data are collected and maintained for each independent licensed provider. Training on the tools and guidelines will be provided. Quality Management will periodically review to ensure compliance with requirements.

Target date for completion: August 31, 2011

The Chief, Anesthesia Service will collaborate with all Clinical Service Chiefs and providers requesting/requiring "out of OR airway management privileges" to ensure that initial and renewal of privileges are documented appropriately. Staff of the Credentialing and Privileging Office will ensure that the required documentation is maintained and will immediately notify the Chief, Anesthesia Service, the Clinical Service Chief, and the provider if there is a failure in the documentation process.

Recommendation 6. We recommended that processes be strengthened to ensure that all violent incidents involving patients are discussed at the DBC.

Concur

Target date for completion: October 1, 2011

Chief, Police Service will send all reports of violence involving patients to the DBC for review. A standing agenda item for the DBC will include the review of this report and subsequent action(s). Chief, Police Service will revise all applicable policies to reflect change in procedure.

Recommendation 7. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: Ongoing

N95 fit testing of the 14 employees identified during the review was completed June 2011. A tracking system has been developed to document compliance with fit testing.

Blood borne pathogen training tracking system is currently in place. The Talent Management System has an automatic electronic alert to employees indicating the need to complete the module. The immediate supervisor also receives the alert and will be responsible for ensuring that employees are compliant with annual requirements.

Recommendation 8. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Concur

Target date for completion: October 1, 2011

A draft Medical Center Memorandum and procedure was developed during the week of the OIG CAP Review. Social Work Service, Chaplain Service, Business Management Service, and Patient Care Service will collaborate to finalize the Medical Center Memorandum and procedure to ensure that all components of a written Advance Directive notification are provided to patients and that the notification is documented in the medical record.

OIG Contact and Staff Acknowledgments

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