



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

Office of Healthcare Inspections

Report No. 13-04195-180

Healthcare Inspection

Quality of Care Concerns Hospice/Palliative Care Program VA Western New York Healthcare System Buffalo, New York

June 9, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations that staff prematurely referred critically ill patients in the intensive care unit (ICU) to the Hospice/Palliative Care Program at the VA Western New York Healthcare System, Buffalo, NY for hospice care and that providers inappropriately prescribed opioid medications to sedated patients receiving hospice care. Because the system predominantly provides hospice care in the community living center (CLC), we expanded our review to include CLC patients as well as those who received hospice care in the ICU.

We did not substantiate the allegations that staff prematurely referred ICU patients to palliative care or that sedated ICU patients received opioid medications that were inappropriate.

We found that because providers in the CLC used narrative text orders for dose increase instructions, pharmacy and on-call physicians were, at times, unaware of opioid medication dose increases made by the CLC nursing staff. In addition, narrative text orders related to opioid infusions placed responsibility for dose increases solely with nursing and lacked recognition of drug pharmacokinetics. Portions of required nursing documentation of patient pain assessments and reassessments were lacking and scanning of paper opioid infusion records was incomplete in both the CLC and ICU.

We recommended that the VA Western New York Healthcare System Director strengthen processes in the CLC to prevent the use of narrative text orders for medication dosing instructions and ensure that opioid titration orders in the CLC contain titration parameters. We also recommended that nursing pain assessment documentation adhere to Veterans Health Administration, Veterans Integrated Service Network, and local policies and that copies of paper records are available in electronic health records.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 11–14 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations that staff at the VA Western New York Healthcare System, Buffalo, NY (system) prematurely referred critically ill patients in the intensive care unit (ICU) to the Hospice/Palliative Care Program for hospice care and that providers inappropriately prescribed opioid medications to sedated patients receiving hospice care. Because the system predominantly provides hospice care in the community living center (CLC), we expanded our review to include CLC patients as well as those who received hospice care in the ICU.

Background

The system is part of Veterans Integrated Service Network (VISN) 2 and serves veterans in central and western New York and northern Pennsylvania.

The system comprises two campuses, one located in Buffalo, NY, and one in Batavia, NY, as well as six community based outpatient clinics. The Buffalo campus consists of a 199-bed tertiary care facility. The facility is a referral center for cardiac surgery, cardiology, and cancer care and is affiliated with the State University of New York at Buffalo School of Medicine and Biomedical Sciences. Other specialty services provided at the facility include hospice/palliative care, home based primary care, dentistry, and Alzheimer's disease and dementia care. The Batavia campus provides geriatric and rehabilitation services, residential post-traumatic stress disorder care for men and women, and outpatient services.

On September 18, 2013, the OIG's Hotline Division received allegations that system staff prematurely referred critically ill patients in the ICU to the Hospice/Palliative Care Program for hospice care and that sedated patients receiving hospice care in the ICU received inappropriate opioid pain medications.

Palliative Care. Palliative care is a specialized form of medical, emotional, spiritual, and psychosocial care that emphasizes symptom control for patients with life limiting or serious disease processes. Because patients who receive palliative care may or may not have a time-limiting prognosis, treatment may include both comfort measures and curative interventions.¹

Hospice Care. Hospice or end-of-life care is specialized palliative care for patients with, generally, a life expectancy of 6 months or less, who are no longer seeking curative treatment for a terminal illness. The focus of palliative care for patients who choose hospice is on achieving a pain-free and dignified death.

¹ VHA Directive 2008-066, *Palliative Care Consult Teams*, October 23, 2008.

The system's Hospice/Palliative Care providers facilitate services and treatment for hospice patients in the CLC and respond to palliative care and hospice care consults system wide. Hospice/Palliative Care providers may provide consult services to patients on any unit and may facilitate transfers to a hospice care bed in the CLC. According to ICU and CLC staff, if hospice care beds are not available or a patient's life expectancy is determined to be less than 72 hours, patients may remain in the acute care setting with the Hospice/Palliative Care Team acting as consultants to attending physicians.

Scope and Methodology

We interviewed the complainant to clarify the allegations. We reviewed system policies, procedures, medical by-laws, industry standards, medical literature, and ICU morbidity and mortality statistics. We reviewed ICU consults to the Hospice/Palliative Care Program placed during fiscal years (FYs) 2012 and 2013 and the electronic health records (EHRs) of the 30 patients who died in the ICU during FYs 2012 and 2013 who had received a palliative care or hospice consult.

Because the majority of patients are admitted to the CLC after being accepted into the Hospice/Palliative Care Program, we expanded our review to include those patients. We reviewed the EHRs of all 99 patients who died in the CLC from January 1, 2013, through September 22, 2013.

We conducted a site visit November 4–6, 2013, and interviewed an attending physician of the Hospice/Palliative Care Program, three ICU intensivists, the Chief of Surgery, the Chief of Cardiology, pharmacy personnel, several nurses, and a nurse practitioner. The Physician Director of the Hospice/Palliative Care Program was away on extended leave and therefore unavailable for interview.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Consults

We did not substantiate the allegation that staff prematurely ordered palliative care consults for patients in the ICU. Staff placed palliative care consults for a variety of supportive palliative care services and not solely for hospice care.

Veterans Health Administration (VHA) defines palliative care consults as “requests by physicians or other health care professionals to a palliative care team to assist in treating patients who have a life-limiting or serious illness.”² However, consults are not restricted to patients who have a terminal diagnosis. Palliative care treatment may include, but is not limited to, performing physical assessments and making recommendations related to prognosis; pain and symptom management; determining goals of care and associated treatment decisions; advanced care planning; and psychosocial, emotional, and spiritual support.

VHA does not provide guidance or criteria concerning when providers should order a palliative care consult for hospice care or guidelines for palliative care consultants to determine if hospice care is appropriate. Providers must rely on local policies and industry standards to help make this decision. The system’s local policy defines the hospice care patient as having a life expectancy of 3 months or less with a Karnofsky Performance Scale³ of 40 percent or below.⁴ In addition, the system’s palliative care team policy includes a list of diagnoses to assist providers in determining if a patient’s condition warrants a palliative care consult for hospice care.⁵

ICU attending physicians often use the same criteria as providers in other hospital settings to determine when palliative care consults for hospice care are appropriate. However, because most patients in ICU are critically ill and heavily sedated, assessing for functional status, such as the Karnofsky Performance Scale, may be difficult. To assist ICU staff in making appropriate consults for hospice care, the palliative care industry has established several criteria or triggers such as the number of admissions to the ICU and/or an ICU length of stay of more than 7 days. Facilities are encouraged to tailor specific ICU criteria from industry resources and to implement and evaluate the criteria through an organized process involving key staff.⁶

² VHA Directive 2008-066, *Palliative Care Consult Teams*, October 23, 2008.

³ The Karnofsky Performance Scale is a functional assessment based upon a measurement of 0 to 100 percent, with 0 as death and 100 as perfect health. Hospice programs often use the scale as a predictor of end of life.

⁴ CM 111-28, *Admission Criteria to Community Living Center for Hospice and Palliative Care*, August 1, 2011.

⁵ CM 11-049, *Advanced Illness/Palliative Care Consult Team*, January 28, 2013.

⁶ Judith Nelson, MD, et al., *Choosing and Using Screening Criteria for Palliative Care Consultation in the ICU: A Report From the Improving Palliative Care in the ICU Advisory Board (IPAL-ICU)*, *Critical Care Medicine Journal*, 41 (October 2013): 2319–2323.

To ensure that providers appropriately identify hospice patients, the system's ICU recently instituted a procedure based on the industry standard that patients receive a palliative care consult after 7 days of care in the ICU. According to interviews with staff and physicians, however, the development of the procedure did not include discussion with or input from all of the ICU attending and sub-specialty physicians. Shortly after instituting the new procedure, the Chief of Surgery started having weekly meetings with palliative care and ICU attending and subspecialty physicians to foster communication concerning this procedure and the initiation of palliative care consults.

Patient Record Review. We reviewed the EHRs of all 130 patient deaths that occurred in the ICU during FYs 2012 and 2013. We identified that 43 of the 130 patients had received palliative care consults; however, 13 of these consults were not for hospice care but for other reasons, such as completion of advance directives.

Prior to ordering consults for the 30 patients in ICU who received hospice care, ICU attending physicians documented prognosis, medical progress, co-morbidities, and, if appropriate, progress towards weaning from mechanical ventilation. We also found that each consult completed by the palliative care physicians included a Karnofsky Performance Scale assessment of 40 percent or less and a review of the patient's history and prognosis. All 30 patients had several life threatening issues and died within 48 hours of admission to hospice care.

The majority of patients, 87 of 130 (67 percent), who died in the ICU during the review period did not have palliative care consults ordered. In addition, 13 of 43 (30 percent) of the palliative care consults were not for hospice care.

Issue 2: ICU Pain Medication

We did not substantiate that providers inappropriately prescribed opioid medications to sedated patients receiving hospice care.

VHA defines an ICU as a special care unit dedicated to the management of acute illnesses, injuries, or post-operative care in which life or organ function may be in jeopardy. An ICU provides a higher level of medical services, medical technology, and staffing compared with other medical or surgical units.⁷ Patients generally require hourly monitoring and treatment and may require mechanical ventilation. In addition, patients are often unable to communicate issues such as anxiety and pain. To promote patient comfort and safety, ICUs commonly institute sedation and analgesic protocols that include frequent, evidenced-based assessments for pain, anxiety, and agitation; treatments that use both opioids and sedatives; and algorithms that direct drug escalation and de-escalation based

⁷ VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

on the assessments.⁸ These protocols utilize different types of assessment scales to accommodate those who can communicate and those who cannot communicate their distress or pain.⁹

When hospice care is instituted in the ICU, patients not only cope with the suffering and distress caused by terminal illness symptoms, but also may have severe distress when mechanical ventilation is discontinued. Because patients may experience severe pain while sedated, and pain medications, such as opioids, do not usually induce and maintain sleep or sedation, ICU staff often continue to use both sedation and pain medications to ensure the patient's comfort during this care. The goal, whether the patient is in the ICU or a Hospice care unit, is to prevent patient suffering and distress; thus, using both types of medications is often necessary to accomplish this goal. Doses for both types of medications are titrated to achieve comfort based upon patient assessments and symptoms.¹⁰

Local policies include pain management,¹¹ sedation and analgesic protocols,¹² and medical management in situations where providers withhold or withdraw life-sustaining treatment at the request of patients or their designated proxies.¹³ All of these policies stress specific assessment criteria and individual care planning using measurement tools for pain, anxiety, and agitation. To enhance ICU management of a patient's pain and other symptoms, the recently drafted ICU policy directly links industry pain and sedation measurement tools with updated algorithms to control a patient's pain, agitation, and anxiety.¹⁴

We reviewed the EHRs of all 30 patients who died while receiving hospice care in the ICU during FYs 2012 and 2013. Discontinuation of mechanical ventilation was included in the hospice care plans for 18 of the 20 patients who had mechanical ventilation. All 18 patients had sedation and pain medications or protocols ordered. Two patients died prior to discontinuation of their mechanical ventilation; however, they received appropriate pain medications and/or had appropriate sedation protocols ordered. The 10 patients who did not have mechanical ventilation received medications for pain and agitation as needed. Medications varied depending on the clinical assessments made by attending physicians.

⁸ William D Schweickert, John P Kress, *Strategies to Optimize Analgesia and Sedation*, Critical Care 2008, 12 (Supplement 3):S6.

⁹ VHA Directive, 2009-053, *Pain Management*, October 28, 2009.

¹⁰ E. Kompanije, B. Van Der Hoven and J. Bakker, *Anticipation of distress after discontinuation of mechanical ventilation in the ICU at the end of life*, Intensive Care Med 2008 September; 34 (9): 1593-1599.

¹¹ CM 11-59, *Pain Management*, February 1, 2011.

¹² CM 11-16, *Intensive Care Unit*, June 1, 2012.

¹³ CM 11-73, *Comfort Measures and Medical Management in Situations Where Life-Sustaining Treatment is Withheld or Withdrawn*, September 1, 2011.

¹⁴ CM 11-16 Revision Draft, *Intensive Care Unit*, proposed October 1, 2013.

Issue 3: Opioid Infusion Orders in the CLC

The EHRs of hospice patients receiving care in the CLC did not always contain current information regarding increases in opioid infusion rates thus potentially compromising pain control.

Often pain management for hospice patients is delivered through infusions that are patient or nurse controlled to address the timeliness, effectiveness, and safety of medication administration. These types of infusions are administered via a patient controlled analgesia (PCA)¹⁵ system or a nurse controlled analgesia (NCA) system where a patient's assigned nurse acts as an authorized agent to administer the medication.¹⁶

PCA allows patients to administer pre-determined doses of pain medication via a programmed PCA pump. Many facilities routinely utilize PCA or NCA for post-surgical pain management, chronic cancer pain, and/or pain associated with hospice or palliative care diagnoses. PCA has the benefit of allowing the patient to individualize pain control to balance pain relief with the amount of medication side effects they find tolerable.

Orders for PCA or NCA can include one or more of the following components:

- A loading or bolus dose is an initial dose used to bring the patient's pain under immediate control.
- The basal or continuous infusion rate is the amount of medication continuously delivered to the patient at a rate sufficient to maintain pain control. A provider will assess whether or not a basal or continuous rate is necessary, or if pain control will be adequate with PRN¹⁷ doses alone.
- A patient demand or PRN dose refers to the amount of medication dispensed each time the patient or nurse activates the pump.
- The lockout interval refers to the required time between PRN doses when the patient or nurse is unable to activate the pump.
- Titration of a dose refers to the increase or decrease of an infusion rate based upon specific parameters. Local policy requires that any order for titration will contain parameters within which the dose will be titrated.¹⁸

¹⁵ CM 11-61, *Management of Basal Rate and Patient Controlled Opioid Infusions*, May 1 2010.

¹⁶ VA Healthcare Network Upstate New York, Network Memorandum 10N2-125-08, *Network Opioid Infusions*, March 4, 2008.

¹⁷ Pro re nata – according to circumstances or as necessary.

¹⁸ CM 119-09, *Prescribing, Transcribing and Verification of Inpatient Orders and of In-Clinic Injectable Orders* May 29, 2013.

Patients who are physically and mentally capable of using the required equipment are eligible for PCA. VISN policy allows NCA with appropriate lockout options for patients who are unable to use PCA and for those in the hospice setting.¹⁹

When providers enter opioid infusion orders into the Computerized Patient Record System (CPRS), the system routinely forwards the orders to a pharmacist to review and complete. With the exception of emergencies, all medication orders are considered incomplete prior to the pharmacist's review and do not appear on medication administration records for nurses to administer. Narrative text orders are useful for communicating patient care orders to nurses, such as instructions for oral care that are not pharmacy related. CPRS does not automatically forward narrative text orders to pharmacy for review and narrative text orders do not appear on medication administration records.

Pharmacy is unaware of dose increases when providers place those instructions in narrative text orders. In addition, on-call providers renewing patient opioid infusion orders are at risk for renewing opioid infusions at incorrect basal rates and/or PRN dosages, compromising patient pain control.

After reviewing the EHRs of the 99 hospice and palliative care patients who died in the CLC between January 1, 2013, and September 22, 2013, we found that 8 patients received opioids via PCA or NCA. The EHRs of six patients included narrative text orders to increase the NCA or PCA basal rate by a prescribed amount each time nurses administered a specified number of PRN doses but did not specify an upper basal dose limit. In addition to being a narrative text order, which was not available for review by subsequent providers or pharmacy, this type of order placed full responsibility for dose titration upon the nurse and provided no guidance regarding dose increase intervals relative to the pharmacokinetics of the opioid being administered. Thus, nursing staff controlled adjustments of opioid infusion basal rates without medical intervention.

In addition to issues viewing the narrative text orders, facility on-call providers and pharmacists, unless physically on a unit at the patient's bedside, were unable to review paper documentation nurses used to document assessments or treatment changes. In compliance with local policy, nurses recorded basal dose increases using a paper record called the controlled substance infusion record (CSIR) in lieu of the bar code medication administration (BCMA) system.²⁰ Nurses and managers reported that the CSIRs remained on the unit until completed or no longer in use and were subsequently scanned into each patient's EHR. Therefore, during the time the CSIR is on the unit, it is not available to on-call providers or pharmacists who are using the EHR to track patient medications and condition changes.

¹⁹ VA Healthcare Network Upstate New York, Network Memorandum 10N2-125-08, *Network Opioid Infusions*, March 4, 2008.

²⁰ CM 11-61, *Management of Basal Rate and Patient Controlled Opioid Infusions*, May 1 2010.

Because providers in the CLC used narrative text orders to instruct nurses on the increases for opioid infusion rates, the risk existed for on-call physicians to renew opioid infusions at incorrect rates or renew PRN doses at incorrect dosage levels thus compromising patient pain control. Furthermore, because on-call providers who renewed expiring orders on weekends, holidays, evenings, or nights used the latest infusion rate information documented in the EHR, they were unaware of rate increases that nurses had documented on the CSIRs. As a result, the possibility existed for inconsistency between the renewed opioid infusion orders in the EHR and actual infusion rates, which would potentially compromise pain control. Although not reflected in the EHRs we reviewed, the potential existed for pharmacy to supply insufficient medication due to rate inconsistencies between the EHR and the CSIR.

Issue 4: Pain Management Nursing Documentation

We found that nursing documentation of pain assessments and reassessments for non-communicative patients was inconsistent or absent in the EHRs. In addition, we found that CSIRs were not consistently scanned into individual EHRs.

Routine assessment for the presence of pain is required for communicative as well as non-communicative patients. When assessing pain in non-communicative patients, nurses observe for signs that could indicate pain. Complete pain assessment also involves monitoring the effectiveness of pain management interventions by reassessing the patient after the pain medication has been given. VHA and local policies require nurses to document assessment and reassessment screenings for pain in non-communicative patients with the code "99" to indicate that the patient is unable to communicate.^{21,22}

To ensure that providers manage a patient's treatment for pain appropriately, the health record should include nursing observations, assessments, and reassessments of the patient's pain and reaction to pain medication.²³

In addition to code 99, nursing staff are required to document their observations of non-verbal pain behaviors such as crying, guarding,²⁴ grimacing, irritability, moaning, or rubbing. Documentation should also include potential causes of pain, surrogate reports of pain, and an estimate of pain intensity. The documentation of pain behaviors and response to pain medication helps providers assess whether current pain regimens are adequate.²⁵

We reviewed the nursing documentation for 258 PRN pain doses recorded in BCMA as administered to all 99 Hospice/Palliative Care patients who died in the CLC from

²¹ VHA Directive 2009-053.

²² CM 11-59, *Pain Management*, February 1, 2011.

²³ VHA Directive 2009-053, *Pain Management*, October 28, 2009.

²⁴ An involuntary reaction to protect an area of pain.

²⁵ VHA Directive 2009-053.

January 1, 2013, through September 22, 2013.²⁶ Of the PRN doses reviewed, 143 (55 percent) contained code 99 as documentation of the initial pain assessment. However, 117 (82 percent) lacked documentation in BCMA, the vital signs package, or progress notes indicating the type of patient behavior that led the nurse to determine the patient was in pain and required a PRN dose of pain medication. One patient had no reassessment documented. Of the 257 pain reassessments we reviewed, 142 (55 percent) contained code 99 as documentation of pain resolution. However, 84 (59 percent) of the documented reassessments had no description of the behavior that led the nurse to determine whether the patient's pain had been adequately resolved.

We reviewed nursing documentation for 25 PRN doses recorded in the EHRs of all 30 patients who died while receiving hospice care in the ICU during FYs 2012 and 2013.²⁷ Of the 25 PRN doses reviewed, 19 had either no assessment documented or code 99 with no description of the patient's behavior. Additionally, 14 pain reassessments had either no documentation of the medication effectiveness or code 99 with no description of the patient's behavior at the time of the reassessment.

In addition to or in lieu of pain assessment and reassessment documentation, the ICU Sedation and Analgesia Protocol²⁸ required that nursing staff assess a patient's pain using the Richmond Agitation Sedation Scale (RASS).²⁹ Though commonly used to assess sedation and agitation, RASS assessments may also indicate symptoms of pain when a patient is unconscious or unable to respond to questions. Twelve of the 15 patients who received pain medication based upon the Sedation and Analgesia Protocol lacked documentation of RASS assessments.

Scanning. When patients receive pain medication via PCA or NCA, local policy requires that nurses in the ICU and CLC track the basal or continuous rates and/or PRN doses on the CSIR. According to nursing staff on the ICU and CLC units and local policy, the CSIRs are kept at the patient's bedside and, once completed, are scanned into EHRs.³⁰

We could not find a scanned copy of the CSIR in 6 of the 8 EHRs of patients who received PCA or NCA in the CLC nor in 12 of the 15 EHRs of patients who received NCA in the ICU.

We found that ICU and CLC nursing staff did not consistently follow VHA and local policies for assessment and reassessment of a patient's pain, nor did they consistently document the assessments and reassessments they completed. When documentation was completed, it was not consistently scanned into the EHR as required by local procedures.

²⁶ We reviewed the first three PRN pain doses documented in BCMA for each of the 99 patients reviewed. Some patients were administered fewer than three doses.

²⁷ For ICU patients we reviewed the last three PRN doses administered. However, 12 records were missing dosage documentation, 8 patients had no prn pain medications ordered, and 2 patients received less than three doses.

²⁸ CM 11-16, *Intensive Care Unit*, June 1, 2012.

²⁹ RASS is a measurement tool used by clinicians to assess levels of sedation/agitation through observation.

³⁰ CM 11-61, *Management of Basal Rate and Patient Controlled Opioid Infusions*, May 1 2010

The lack of consistent documentation and information in the patient's EHR increased the risk that providers would not have essential information to assist them in making medical decisions concerning a patient's care.

Conclusions

We did not substantiate the allegations that staff prematurely referred ICU patients to palliative care or that sedated ICU patients received opioid medications that were inappropriate.

Palliative care consultants performed appropriate assessments to determine whether patients should receive hospice care. The system investigated industry standards for additional criteria to identify hospice patients and system medical leadership instituted weekly meetings in the intensive care unit to facilitate communication and understanding between palliative care and intensive care unit providers.

Established intensive care unit industry standards support using analgesic as well as sedation protocols for hospice care patients whose medical care is affected by their level of consciousness. The system's practice to provide analgesic medications to sedated patients fell within accepted industry standards.

Six of eight orders for opioid PCA or NCA infusions in the CLC included narrative text orders for increasing the basal rate with no dose titration limit specified. In addition, the use of narrative text orders placed responsibility for dose increases solely with nursing and lacked recognition of drug pharmacokinetics.

Portions of required nursing documentation of patient pain assessments and reassessments were lacking and scanning of paper opioid infusion records was incomplete in the both the CLC and ICU.

Recommendations

1. We recommended that the System Director strengthen processes in the community living center to prevent the use of narrative text orders for opioid patient controlled analgesia or nurse controlled analgesia and that opioid titration orders include titration parameters.
2. We recommended that the System Director strengthen processes to ensure that nursing pain documentation adheres to Veterans Health Administration, Veterans Integrated Service Network, and local policies and that copies of paper records are available in electronic health records.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 8, 2014

From: Director, VA Healthcare Upstate New York (10N2)

Subject: **Healthcare Inspection—Quality of Care Concerns,
Hospice/Palliative Care Program, VA Western New York
Healthcare System, Buffalo, NY**

To: Director, Bedford Office of Healthcare Inspections (54BN)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

- I. Thank you for the opportunity to review and respond to the subject report.
- II. I have carefully reviewed your draft report, and I concur with the findings and recommendations. I have also reviewed the information provided by the VA Western New York Healthcare System and I am submitting it to your office as requested. The facility plan for correction is included.


F01 Darlene A. DeLancey, MS

System Director Comments

**Department of
Veterans Affairs**

Memorandum

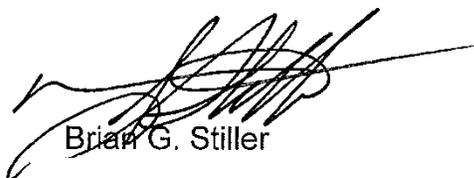
Date: May 8, 2014

From: Director, VA Western New York Healthcare System (528/00)

Subject: **Healthcare Inspection—Quality of Care Concerns,
Hospice/Palliative Care Program, VA Western New York
Healthcare System, Buffalo, NY**

To: Interim Network Director, VA Healthcare Upstate New York (10N2)

1. Thank you for the opportunity to review and respond to the subject report.
2. I have carefully reviewed your draft report, and I concur with the findings and recommendations. The facility plan for correction is included.
3. If you have any questions or need further information, please contact Ms. Patricia Lind, Associate Director for Patient Nursing Services, VA Western New York Healthcare System, at 716-862-8537.



Brian G. Stiller

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 the System Director strengthen processes in the community living center to prevent the use of narrative text orders for opioid patient controlled analgesia or nurse controlled analgesia and that opioid titration orders include titration parameters.

Concur

Target date for completion: June 30, 2014

System response:

1. A work group will be chartered by May 16, 2014 and closed by June 20, 2014 to look at the appropriate manner in which opioid medications are ordered/re-ordered for administration using PCA/NCA pumps.
2. Additionally the work group will determine a process for documentation of opioid dosage increases using BCMA.
3. This work group will consist of the following disciplines: Physicians from palliative care and medicine, pharmacy and other staff as determined by the Chief of Staff and the Associate Director of Patient Nursing Services.
4. Education will be provided to providers to ensure that the orders are correctly entered into CPRS.
5. Electronic Medical Records (EMR) will be audited to determine compliance with CPRS order entry. Require 90% compliance for 3 consecutive months.
6. Remedial education to CLC and ICU ward clerk and nursing staff that completed CSIR forms will be scanned to CPRS per VHA, VISN and local policy.
7. The EMRs of patients receiving opioid medication per PCA/NCA will be audited for compliance of scanned documents to ensure that the documentation is accurate and complete. Require 90% compliance for 3 consecutive months.

Recommendation 2. We recommended that the System Director strengthen processes to ensure that nursing pain documentation adheres to Veterans Health Administration, Veterans Integrated Service Network, and local policies and that copies of paper records are available in electronic health records.

Concur

Target date for completion: May 30, 2014

System response:

1. Remedial education to CLC and ICU professional nursing staff regarding documenting observations for pain 99 patients according to VHA, VISN and local pain management policies.
2. This education to include documentation of the following: The type of behavior that led the nurse to determine the patient was in pain and required medication and monitoring the effectiveness of the pain medication.
3. Audit of CLC and ICU BCMA records for documentation of reason for parental opioid infusion.
4. Audit of CLC and ICU BCMA records for documentation of PRN effectiveness. Require 90% compliance for 3 consecutive months.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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