Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03445-97

Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania

March 17, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of November 26–30, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Wilkes-Barre VA Medical Center (the medical center), Wilkes-Barre, PA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided four fraud and integrity awareness briefings to 266 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered four operational activities. We made recommendations in three of the activities reviewed. For these activities, the medical center needed to:

- Comply in full with Veterans Health Administration (VHA) patient safety standards for inspections of locked mental health units.
- Reassess the number of employees needed to participate in annual respirator fit-testing to support current infectious disease programs.
- Ensure that all designated environment of care (EOC) team members participate in all EOC rounds and that all community based outpatient clinics (CBOCs) are inspected semi-annually.
- Ensure that dirty utility rooms are locked.
- Document Peer Review Committee (PRC) discussion of recommendations for improvement in patient care and analyze trends and findings.
- Improve processing times for root cause analyses (RCAs) and implement a central QM database to track action items to completion.
- Develop and implement an action plan for improvement of patient satisfaction based on Survey of Healthcare Experiences of Patients (SHEP) data results.

The medical center complied with selected standards in the following activity:

- Computerized Patient Record System (CPRS) Business Rules.

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

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–16 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is located in Wilkes-Barre, PA, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven CBOCs in Allentown, Bangor, Berwick, Pottsville, Sayre, Williamsport, and Tobyhanna, PA. The medical center is part of VISN 4 and serves a veteran population of about 203,500 throughout its service area of 20 counties.

Programs. The medical center provides primary and tertiary care services in the areas of medicine, surgery, psychiatry, physical medicine, rehabilitation, neurology, oncology, dentistry, hematology, and nephrology. Additionally, the medical center offers geriatric and extended care services, including long-term care, telemedicine, respite care, dementia care, hospice, transitional care, and home care. Specialized programs include preservation and amputation care, visual impairment services, tele-home health care, post-traumatic stress disorder clinical teams, substance abuse residential treatment, and traumatic brain injury services. The medical center has 79 hospital beds and 105 nursing home beds.

Affiliations and Research. The medical center is affiliated with Drexel University's College of Medicine, St. Luke's Hospital and Health Network, Lake Erie College of Osteopathic Medicine, and the Pennsylvania College of Optometry. The medical center successfully established a research program during fiscal year (FY) 2006 and has two active research projects.

Resources. In FY 2007, medical care expenditures totaled $172.3 million. The FY 2008 medical care budget is $173.3 million. FY 2007 staffing was 1,009.5 full-time employee equivalents (FTE), including 71.9 physician and 254.1 nursing FTE.

Workload. In FY 2007, the medical center treated 42,035 unique patients and provided 15,490 inpatient days in the hospital and 36,456 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 2,523 discharges, and the average daily census, including nursing home patients, was 151.7. Outpatient workload totaled 346,154 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following four activities:

- CPRS Business Rules.
- EOC.
- QM.
- SHEP.

The review covered medical center operations for FY 2006, FY 2007, and FY 2008 through November 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Wilkes-Barre, Pennsylvania,* Report No. 03-01357-61, January 12, 2004). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented four fraud and integrity awareness briefings for 266 employees. These briefings covered procedures for reporting suspected criminal activity

to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether the facility had established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration (OSHA), and Joint Commission[1] standards. To evaluate EOC, we inspected occupied and unoccupied patient rooms, bathrooms, emergency carts, unit supply rooms, and areas where medications were stored on the inpatient units (medicine, surgery, intensive care, behavioral health). We also inspected the emergency department and the NHCUs. Clinical and non-clinical areas were inspected for cleanliness, safety, infection control, and general maintenance. Overall, we found the facility to be clean and well maintained. Interim Life Safety Measures were implemented and monitored at all construction sites. The following conditions required management attention.

Locked Mental Health Units. The VHA mental health EOC checklist and protocol is used to identify environmental safety concerns on locked mental health units. The protocol directs the establishment of a Multidisciplinary Safety Inspection Team. Prior to conducting rounds on a quarterly basis, the team must be trained to identify environmental hazards that pose a threat to suicidal patients. All team findings, actions, and outcomes from these rounds should be tracked on the "Risk Assessment and Abatement Tracking" spreadsheet.

We found that the team and the staff on Ward 9 did not receive training, that spreadsheet ratings were inconsistent

[1] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

with the acuity of the findings, and that the team lacked the following staff members:

- Psychiatrist.
- Psychiatric nurse manager.
- Non-psychiatric nurse manager.
- Mental health worker.
- Suicide prevention coordinator.

Respirator Fit-Testing. VHA policy for respirator fit-testing[2] directs medical centers to designate a minimum number of individuals required to support current infectious disease programs based on local needs and a clear strategy. Individuals identified to wear an N95 respirator[3] must undergo initial and annual fit-testing, training, and medical evaluation. Individuals identified to wear powered air purifying respirators[4] are exempt from fit-testing requirements but must complete the training and medical evaluation requirements. The medical center has designated high-risk areas and identified a core group of individuals who need respirators. Three hundred ancillary employees have also been identified to participate in the fit-testing program. Due to the number of employees identified to participate in the program, safety and environmental staff are challenged to conduct fit-testing, perform training, and schedule medical evaluations for all employees annually.

Environment of Care Rounds. EOC rounds by the medical center inspection team allow management-level staff to identify and correct sanitation discrepancies, unsafe working conditions, and OSHA regulatory violations. Attendance at weekly EOC rounds was inconsistent, and semi-annual inspections of the CBOCs were not consistently conducted. According to local policy, the inspection team, with representation from all required disciplines, is to conduct semi-annual inspections of all areas of the medical center.

Dirty Utility Rooms. According to Joint Commission and OSHA standards, dirty utility rooms must be locked to prevent mishandling of hazardous materials and waste. The

[2] OSHA Standard 1910.134, *Respiratory Protection*, and VHA Health Information Letter 10-2005-023, *Respiratory Protection Used for Infectious Disease and Annual Fit-Testing*.
[3] Respirators filter the air you breathe to help protect you from microorganisms, including bacteria and many viruses. In health care settings, the most common type of respirator is a surgical N95 respirator.
[4] The powered air purifier respirator protects workers against particulates by drawing ambient air through a high efficiency particulate air or HEPA filter and supplying that air through a breathing tube into the hood and facepiece.

dirty utility room doors were marked with appropriate signage, and some were locked; however, all dirty utility room doors needed to be secured. While we were onsite, the medical center took immediate steps to install locks on all dirty utility room doors.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director complies in full with VHA patient safety standards for inspections of locked mental health units.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires reassessment of the number of individuals needed to participate in annual respirator fit-testing to support current infectious disease programs.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that dirty utility rooms are locked.

The VISN and Medical Center Directors concurred with the findings and recommendations and took immediate actions to comply with staffing requirements for the safety inspection team and to install locks on dirty utility room doors. Plans are in place to evaluate the number of employees that need to participate in the fit-testing program, and three CBOCs have been visited by the EOC team since our visit. The corrective actions and implementation plans are acceptable. We consider Recommendations 1 and 4 closed, and we will follow up on the planned actions for Recommendations 2 and 3 until they are completed.

Quality Management

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

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

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate the quality of care at the individual provider level.

The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[5] with subsequent PRC evaluation and concurrence with the findings. The medical center completes 95 percent of all peer reviews within the required timeframes. VHA requires that the PRC document discussions and analyze trends and findings to offer suggestions for improving clinical practices. The PRC minutes contained discussion of individual peer reviews; however, there was no discussion of recommendations for improvement in patient care, and there was no identification and analysis of trends and findings. Multidisciplinary evaluation of findings leads to the best possible care outcomes and stronger organizational performance.

Root Cause Analysis. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires completion of an RCA within 45 days of identification of a sentinel event.[6] We reviewed five individual RCAs; only one was completed within 45 days. It was difficult to determine if corrective actions were initiated or evaluated for effectiveness because the medical center did not use a central database to track the actions to completion. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could not be assured of a comprehensive and efficient patient safety process.

[5] Peer review levels: Level 1– Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

[6] A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC document discussion of recommendations for improvement in patient care and analyze trends and findings.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director improves processing times for RCAs and implements a central QM database to track action items to completion.

The VISN and Medical Center Directors concurred with the findings and recommendations and have implemented action plans to expand PRC meeting minutes to capture discussions concerning improvements in patient care. RCAs will be tracked to ensure timely completion. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center used the quarterly/semi-annual survey report results of patients' health care experiences to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figure 1 on the next page shows the medical center's SHEP performance measure results for inpatients. Figure 2 on the next page shows the medical center's SHEP performance measure results for outpatients.

Figure 1:

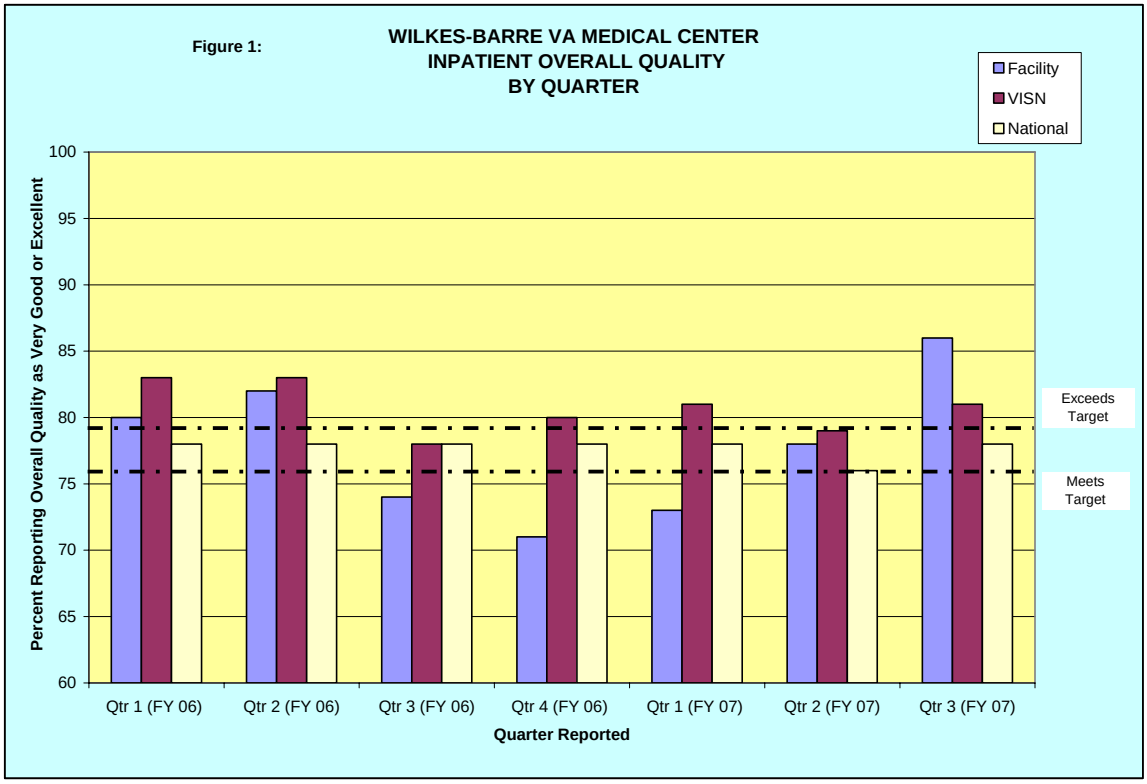
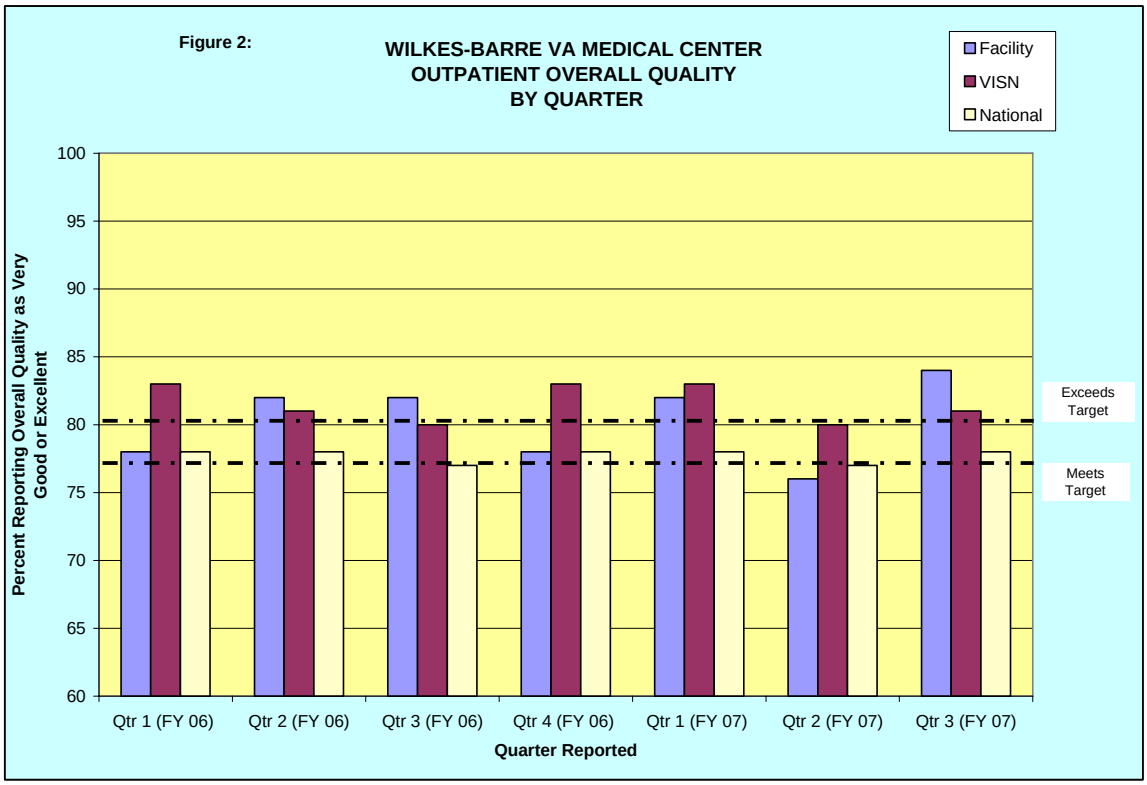


Figure 2:



The medical center met or exceeded the established target in 4 of the last 7 quarters for inpatient overall quality and met or exceeded the established target in 6 of the last 7 quarters of available data for outpatient overall quality. The patient advocate provides customer service training—based on SHEP scores and patient complaints—to new employees during orientation, attends service meetings, and visits the CBOCs. Also, the patient advocate tracks and trends data related to customer service and reports quarterly to the Performance Improvement Steering Committee. However, neither the medical center nor the individual service lines has an action plan in place to collect and analyze patient advocate and SHEP data even though VHA directed the development of action plans by April 2007.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director oversees the development and implementation of an action plan for improvement of patient satisfaction based on SHEP data results.

The VISN and Medical Center Directors concurred with the findings and recommendation and will develop and implement an action plan for improvement of patient satisfaction. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Computerized Patient Record System Business Rules

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

A communication (software informational patch USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical records system. The OI cautioned that, “the practice of editing a document

that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center's Privacy Officer.

We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. We found that all of the business rules provided to the OIG inspector were in compliance with VHA Handbook 1907.1. The medical center has a CPRS committee that reviews the business rules semi-annually for appropriateness. Also, medical center policy clearly defines the method for retraction of notes by the Privacy Officer. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 11, 2008

From: Network Director, VA Healthcare—VISN D4 (10N4)

Subject: **Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania**

To: Director, Washington, D.C., Healthcare Inspections Division (54DC)

Thru: Director, Management Review Service (10B5)

1. Attached is the response from VAMC Wilkes-Barre, PA, to the recommendations outlined in the OIG CAP report.

2. I have reviewed and concur with the facility Director's comments.

(original signed by:)

MICHAEL E. MORLEAND, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2008

From: Wilkes-Barre VA Medical Center Director

Subject: **Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania**

To: VISN Director

1. VA Medical Center Wilkes-Barre, PA, (WBVAMC) appreciates the professional way the Office of Inspector General (OIG) Combined Assessment Program (CAP) visit was conducted by all CAP team members, as well as the many positive findings and compliments cited by team members during the visit. WBVAMC's comments about OIG's Draft Report follow. Questions may be directed to Ms. Yvonne Bohlander, RN, Quality Manager, at 570-824-3521 ext. 7974.

2. We concur with the intent of the Recommendation 5 but wish to clarify that the meeting minutes of the Peer Review Committee will be expanded to include documentation of the discussions that are occurring about recommendations for improvement in patient care. Also, the individual case reviews currently being done will be expanded to include analysis of trends and findings.

Sincerely yours,

(original signed by:)

Janice M. Boss, M.S., CHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director complies in full with VHA patient safety standards for inspections of locked mental health units.

Concur

Action Plan: The Medical Center Director requires compliance with all VHA National Patient Safety standards for locked Mental Health units.

a. Multidisciplinary Safety Inspection Team – added the following members:

- Psychiatrist
- Psychiatric Nurse Manager
- Non-Psychiatric Nurse Manager
- Mental Health Worker (Vocational Rehabilitation Technician)
- Suicide Prevention Coordinator

Completed

b. Training of the team to identify environmental hazards that pose a threat to suicidal patients.

Completed

c. All team findings, actions, and outcomes from these rounds will be tracked on the Risk Assessment and Abatement Tracking spreadsheets.

Completed

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires reassessment of the number of individuals needed to participate in annual respirator fit-testing to support current infectious disease programs.

Concur

Action Plan: The number of employees participating in the fit-testing program will be reevaluated to enable the fit-testing, training, and medical evaluations of the minimum number of individuals required to support current infectious disease programs.

In Progress. Number of employees in the fit-testing program reduced by 62 to date. Target Date for Completion: February 29, 2008

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that all CBOCs are inspected semi-annually.

Concur

Action Plan: The Medical Center Director reiterated the requirement that all designated EOC team members participate in all EOC rounds. All CBOCs are to be inspected semi-annually.

Completed, and ongoing. CBOCs inspected since the November 2007 OIG CAP visit:

12/5/07 – Allentown OPC

1/2/08 – Sayre OPC

1/9/08 – Schuylkill County OPC

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that dirty utility rooms are locked.

Concur

Action Plan: While OIG team was on site, the medical center took immediate steps to install locks on all the dirty utility room doors.

Completed and will be monitored by the EOC Rounds Team.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC document discussion of recommendations for improvement in patient care and analyze trends and findings.

Concur

We concur with the intent of the Recommendation 5 but wish to clarify that the meeting minutes of the Peer Review Committee will be expanded to include documentation of the discussions that are occurring about recommendations for improvement in patient care. Also, the individual case reviews currently being done will be expanded to include analysis of trends and findings.

While onsite, the OIG CAP Team found, through interview, that Peer Review Committee discussions were occurring regarding improvements in patient care. The recommendation conveyed to the staff was to expand the Peer Review Committee minutes to include that discussion. Additionally, the individual case reviews presented should include analysis of trends and findings.

Target Date for Completion: January 31, 2008

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director improves processing times for RCAs and implements a central QM database to track action items to completion.

Concur

Action Plan: Every Root Cause Analysis will be completed within 45 days. The manual suspense system for Root Cause Analysis has been converted to a "stop light" (green, yellow, red) spreadsheet, maintained by Quality Management.

Completed

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director oversees the development and implementation of an action plan for improvement of patient satisfaction based on SHEP data results.

Concur

Concur with improving patient satisfaction as measured by SHEP (Survey of Healthcare Experience of Veterans). We will enhance the existing action plan process to include data capture, analysis and display of SHEP results to improve patient satisfaction."

Customer Service training is provided to new employees during orientation.

On a service level, the Patient Advocate attends service meetings and visits all CBOCs to review SHEP data. Monthly, the Chief of Staff, Nurse Executive, Quality Manager, and Patient Advocate meet with the clinical

service chiefs to review patient complaints/compliments and SHEP data. The Patient Advocate attends monthly Administrative Executive Committee (AEC) meetings, chaired by the Associate Medical Center Director, to dialogue with the administrative service chiefs regarding patient complaints/compliments and SHEP data. The Patient Advocate is a member of the oversight committee, Performance Improvement (PI) Steering Committee, chaired by the Chief of Staff. The Patient Advocate attends monthly and reports quarterly to the PI Steering Committee, including reporting SHEP results and status of corrective actions.

On an executive level, the Medical Center Director presents SHEP data at Town Meetings, Director's Staff meetings, Supervisors' meetings, and by e-mail to all medical center staff, as well as to external stakeholders, such as the Veterans Advisory Council.

An action plan will be developed and implemented for improvement of patient satisfaction, based on these comments. It will exhibit data capture, analysis, and display utilizing the SHEP results.

Target Date for Completion: March 31, 2008

OIG Contact and Staff Acknowledgments

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