



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

Office of Healthcare Inspections

Report No. 08-00399-131

Combined Assessment Program Review of the Battle Creek VA Medical Center Battle Creek, Michigan



May 29, 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 March 3–7, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Battle Creek VA Medical Center (the medical center), Battle Creek, MI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 156 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strength and reported accomplishment:

- Target exceeded for employee influenza vaccinations.

We made recommendations in four of the activities reviewed. For these activities, the medical center needed to:

- Meet Veterans Health Administration (VHA) requirements for peer reviews (PRs).
- Compare patient complaint data to Survey of Healthcare Experiences of Patients (SHEP) results and initiate and monitor corrective actions.
- Monitor the importing and copying of text in electronic medical records.
- Manage adverse event disclosures in accordance with VHA policy.
- Conduct an independent review of the two patients identified during our inspection as having experienced adverse events to ensure that VHA policy is followed.
- Strengthen communication and collaboration between utilization management (UM), medical care cost recovery (MCCR), and fee basis staff.
- Correct infection control vulnerabilities.
- Correct safety vulnerabilities.
- Correct patient privacy vulnerabilities.
- Ensure that computerized patient record system (CPRS) business rules comply with VHA policy and Office of Information (OI) guidance.

- Implement an action plan to improve patient satisfaction that includes measurable goals and assigns responsibility for completion of tasks.

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

- Pharmacy Operations.

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections.

Comments

The Acting VISN and Medical Center Directors agreed with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 16–24, for the full text of the Directors' comments.) We will follow up on all 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 Battle Creek, MI, and offers a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Benton Harbor, Grand Rapids, Lansing, and Muskegon, MI. The medical center is part of VISN 11 and serves a veteran population of about 33,300 throughout the western and lower peninsula of Michigan.

Programs. The medical center provides medical, mental health, and specialty care services. It has 243 hospital, 94 residential rehabilitation, 40 domiciliary, and 241 nursing home beds.

Affiliations and Research. The medical center is not affiliated with a school of medicine but does have affiliations with 19 institutions of higher learning. Affiliated training programs include pharmacy, nursing, optometry, social work, and other allied health professions. In fiscal year (FY) 2007, the medical center's research program had 12 projects. Important areas of research included diabetes, chronic heart failure, tobacco cessation, and hypertension.

Resources. In FY 2007, medical care expenditures totaled about \$154 million. At the time of our review, the FY 2008 medical care budget was pending. As of March 1, 2008, medical center staffing was 1,226.5 full-time employee equivalents (FTE), including 86.5 physician and 222.4 nursing FTE.

Workload. In FY 2007, the medical center treated 33,294 unique patients and provided 31,218 inpatient hospital days, 16,630 residential rehabilitation days, 1,396 domiciliary days, and 33,116 Nursing Home Care Unit days. The inpatient care workload totaled 20,718 discharges. Outpatient workload totaled 257,323 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 five activities:

- CPRS Business Rules.
- Environment of Care (EOC).
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through February 29, 2008, 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, Battle Creek, Michigan*, Report No. 04-00602-171, July 30, 2004). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 156 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.

Organizational Strength

Target Exceeded for Employee Influenza Vaccinations

The Deputy Under Secretary for Health for Operations and Management established a target score of 60 percent for FY 2008 employee participation in the Influenza Vaccination Program. During the 2006–2007 influenza season, the medical center achieved 66 percent participation. In an effort to promote healthy communities, medical center managers organized an employee incentive program to motivate employees to participate in this program. Incentives leading to increased participation included:

- A 59-minute time off award for employees who received the vaccination.
- Required signature declinations of employees who did not wish to participate.
- Enhanced education on influenza.
- Mobile clinics for easy access.
- Decreased waiting times for vaccinations due to pre-drawn doses.

As a result of these efforts, the medical center achieved a remarkable 86 percent employee vaccination rate during the 2007–2008 influenza season.

Results

Review Activities With Recommendations

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 senior managers and key employees. Senior managers were supportive of performance improvement activities. We reviewed plans, policies, committee minutes, and other relevant documents. We also assessed compliance with QM recommendations from the prior CAP review. We identified five program areas that required further management attention.

Peer Review Process. The PR process needed improvement to ensure timely completion of reviews. VHA

policy¹ requires that initial reviews be completed within 45 days and that PR Committee evaluations be completed within 120 days. Of the 19 PRs performed during FY 2007, 4 exceeded 45 days for completion of the initial review, and 9 exceeded 120 days for final evaluation by the committee.

Minutes from the PR Committee were not submitted to an oversight committee, as required by VHA policy. Prior to February 2008, PR Committee minutes were signed off by the Chief of Staff.

Individual PRs were tracked and trended by rating levels² and by changes from one rating level to another. Of the 19 PRs completed, the PR Committee changed 1 from a Level 2 to a Level 1 and 2 from a Level 2 to a Level 3. Recommended actions were identified and implemented; however, actions were not monitored until completion.

Patient Complaints. Patient complaint data was not compared to results of the SHEP survey, as required by VHA policy.³ The patient advocate needed to expand data analysis in the patient complaint program to include comparisons with SHEP scores and identify meaningful trends. Opportunities for improvement were identified from the complaint data collected; however, there were no actions taken.

Medical Record Review. The medical center has a policy⁴ outlining rules for importing and copying text into the electronic medical record. However, we found that managers were not monitoring to ensure that this policy was followed.

Adverse Event Disclosure. When an adverse event occurs as a result of patient care, VHA policy⁵ requires staff to discuss the event with the patient or their representative and inform them of their right to file a claim. We reviewed one adverse event disclosure note documented in a patient's medical record by the Chief of Staff. There was no evidence

¹ VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

² Peer reviews are assigned an individual rating: Level 1 – Most practitioners would have managed the case similarly; Level 2 – Most practitioners might have managed the case differently; Level 3 – Most practitioners would have managed the case differently.

³ VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

⁴ Medical Center Memorandum No. 11-1101, *Medical Records Documentation Standards and Requirements for Completion and Timeliness*, January 2007.

⁵ VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

in this note of a discussion regarding the right to file a claim. We identified two additional adverse event cases that did not include disclosure documentation in the patients' medical records.

Utilization Management. UM staff review patient medical records to determine the appropriateness of admissions and continued hospitalizations and to ensure the appropriate use of health care resources. It is essential that UM staff work closely with staff who are responsible for MCCR and fee basis functions. Medical center policy⁶ states that there must be an established and effective collaboration between the Business Officer or Revenue Coordinator and medical center staff to identify problem areas, initiate corrective actions, facilitate educational opportunities for multidisciplinary staff, and ensure an effective UM program for third-party reimbursement. We determined that there were opportunities to strengthen communication and collaboration between these entities.

Recommendation 1 We recommended that the Acting VISN Director ensure that the Medical Center Director takes action to meet VHA requirements for PRs.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. The PR Committee will meet monthly to focus on backlogged cases and ensure that future reviews meet timelines. PR actions will be monitored until completion and tracked by the PR Committee and the VISN. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient complaint data are compared to SHEP results and that corrective actions are initiated and monitored.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. A Planetree⁷ Coordinator will be hired to implement the Planetree Initiative for patient-centered care. This employee will also oversee the Customer Service Program, which is responsible for comparing patient complaint and SHEP data and identifying

⁶ Medical Center Memorandum No. 115-1025, *Utilization Management Program*, August 2007.

⁷ Planetree is a non-profit membership organization working with hospitals and health centers to develop and implement patient-centered care in healing environments.

improvement actions. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that managers monitor the importing and copying of text in electronic medical records.

The Acting VISN and Medical Center Directors concurred with the finding and recommendation. The Medical Records Committee will monitor the point-of-care medical records review process and follow up as necessary with responsible service chiefs. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that adverse event disclosures are managed in accordance with VHA policy.

The Acting VISN and Medical Center Directors concurred with the finding and recommendation. Incidents with severity codes of "0" or "1" will be forwarded to the appropriate social worker on the day the incident occurs. Incidents with severity codes of "2" or "3" will be referred immediately to the Chief of Staff's Office for either a clinical or institutional disclosure. The Risk Manager will track all incidents and disclosures and report them to the Medical Center Director and attendees of the daily leadership meeting. The Chief of Staff will ensure that all institutional disclosures are documented using the electronic disclosure template in CPRS. An electronic clinical disclosure template will be created and implemented by June 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5

We recommended that the Acting VISN Director ensure that the Medical Center Director conducts an independent review of the two patients identified during our inspection as having experienced adverse events to ensure that VHA policy is followed.

The Acting VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Staff's Office will review the identified patients' care and will follow up in accordance with VHA policy. The improvement plan is

acceptable, and we will follow up on the completion of the planned actions.

Recommendation 6

We recommended that the Acting VISN Director ensure that the Medical Center Director takes action to strengthen communication and collaboration between UM, MCCR, and fee basis staff.

The Acting VISN and Medical Center Directors concurred with the finding and recommendation. An MCCR utilization review nurse position vacancy was filled, and the nurse was trained. Staff from UM, the Medical Administration Service (department that handles fee basis), and MCCR attended a UM Committee meeting and received training. In April 2008, UM oversight was transferred to the Quality Resources Service, which plans to hire three additional UM nurses. UM, the Medical Administration Service, and MCCR will establish criteria for the creation of monthly reports, which will be used to identify and monitor problem areas, initiate corrective actions, facilitate educational opportunities, and ensure an effective program for third-party reimbursement. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center had established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, maintained an effective infection control program, and identified hazards that might pose a safety threat to patients and staff on locked mental health units.

We inspected five patient care units (long-term care, dementia, locked acute mental health, locked geriatric and long-term mental health, and medical). We also followed up on a suggested improvement action from our prior CAP review to install an eyewash station in the Veterans Canteen Service kitchen and found that the medical center had completed that action.

Managers were responsive to identified environmental concerns. The infection control program monitored, trended, and analyzed data and reported results to clinicians for quality improvements. The Multidisciplinary Safety Inspection Team conducted risk assessments of the locked acute mental health unit, and staff were pursuing corrective

actions. The following deficiencies required further management attention.

Infection Control. Emergency call system cords must be accessible and easily cleaned as they are often located in shower areas and near commodes and sinks. The medical center was in the process of changing rope-style cords to plastic cords; however, we noted that several cords were not accessible from the floor. Additionally, we noted the use of rope, tape, and gauze on some overbed light pull cords.

Medication and nourishment refrigerator temperatures must be monitored daily to ensure that the contents are safe. When a refrigerator is found to be out of the acceptable temperature range, an employee needs to initiate corrective action (such as adjusting the temperature control or creating a work order for repair). The action should also be documented on the refrigerator log so that other employees are aware of what was done. We noted that staff did not consistently document actions taken when refrigerator temperatures were out of range. Employees must also inspect the condition of refrigerator door seals to ensure that they are intact and clean. We observed cracked and dirty seals on medication and nourishment refrigerators.

Patient care equipment and furniture needs to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We identified several mattresses, a chair, and a wheelchair with compromised surfaces. We observed that safety straps on some shower chairs were visibly soiled. Also, some tray tables on the medical unit had molding missing from the edges, leaving the pressed wood surface exposed. These tray tables could not be effectively cleaned.

Damaged ceiling tiles need to be replaced to minimize the potential for debris and pest entry. We observed several damaged ceiling tiles during our inspections of the patient care units.

Safety. We observed that individual ceiling panels were used in the hallways of the locked mental health units. We tested random panels to ensure that safety clips were used to restrict removal. We discovered one panel that was not clipped and recommended that the other panels on these units be tested.

Dirty linen receptacles were placed in hallways outside patient shower areas on the locked mental health units. Because these receptacles were in unprotected areas, patients could have accessed the linens to harm themselves or others. The shower control fixtures in the women's shower room on the locked geriatric and long-term mental health unit needed to be replaced as they could be used as anchor points. We also recommended that staff remove hose sprayers from the tubs on this unit when not in use.

Because of the patient population on the dementia unit, extra care must be taken to ensure patients' safety. We observed splintered doors throughout the unit that could cause injury.

Oxygen tanks must be secured and stored so that staff may quickly recognize if the tanks are full or empty. We observed an unsecured empty oxygen tank in the full tank storage room.

Patient Privacy. Federal law⁸ requires that sensitive patient information be secured from unauthorized access. A white marker board with patient names could be viewed from the hallway on a patient unit. Clipboards with full patient names and social security numbers were hanging from handrails outside patient rooms and from patient locker doors. Also, sensitive patient information was accessible at the nurses' station desk in the Special Needs Room on the medical unit.

Recommendation 7

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that infection control vulnerabilities identified during the onsite review be corrected.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. Plastic emergency call system and overbed light pull cords will be installed by June 30, 2008. A remote electronic refrigerator temperature monitoring system will be installed, which will monitor all medication and nourishment refrigerators at the medical center and at the CBOCs. Appropriate personnel will be alerted when a refrigerator temperature is out of range. Staff examined refrigerator door seals on all wards, and identified seals will be cleaned or replaced. Replacement furniture has been ordered. Staff will receive training on identifying and reporting compromised equipment and furniture. Damaged

⁸ Health Insurance Portability and Accountability Act of 1996.

ceiling tiles will be reported through the work order system and monitored on environmental leadership rounds to ensure that corrective action has been taken. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that safety vulnerabilities identified during the onsite review be corrected.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. Ceiling panels on the locked mental health units will be secured. Dirty linen receptacles have been relocated to locked shower rooms. A corrective solution is being explored to address the women's shower room fixtures. Tub hose sprayers were removed. Splintered doors on the dementia unit will be repaired by June 2008, and a project to replace these doors has been approved for FY 2009. Proper storage of oxygen tanks was discussed with nursing staff. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 9

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient privacy vulnerabilities identified during the onsite review be corrected.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. All patient information was secured at the nursing stations. A new electronic system that will eliminate the need for hard copy medical records will be in place by August 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

**Computerized
Patient Record
System Business
Rules**

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. VHA policy⁹ states that "no edits, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the Health Information Management professional or the Privacy Officer (PO)." CPRS business rules define what functions certain

⁹ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

groups or individuals are allowed to perform in the medical record.

On October 20, 2004, VHA's OI provided guidance (software informational patch¹⁰ USR*1*26) that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. 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 instructing all facilities to comply with OI guidance.

We reviewed VHA and medical center policies and interviewed the Chief of Health Information Management Service (HIMS) and Clinical Application Coordinators. One business rule did not limit retraction, amendment, or deletion of a signed medical record note to the PO or the Chief of HIMS. Managers removed this business rule while we were onsite.

Recommendation 10

We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance.

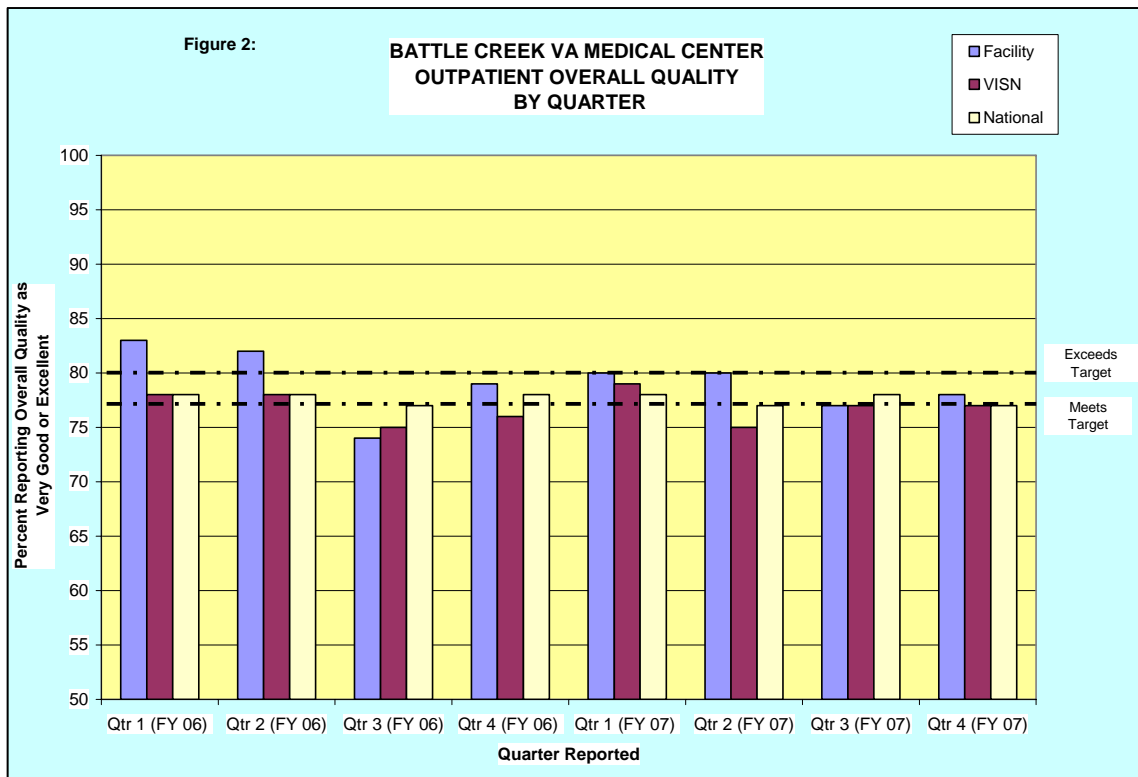
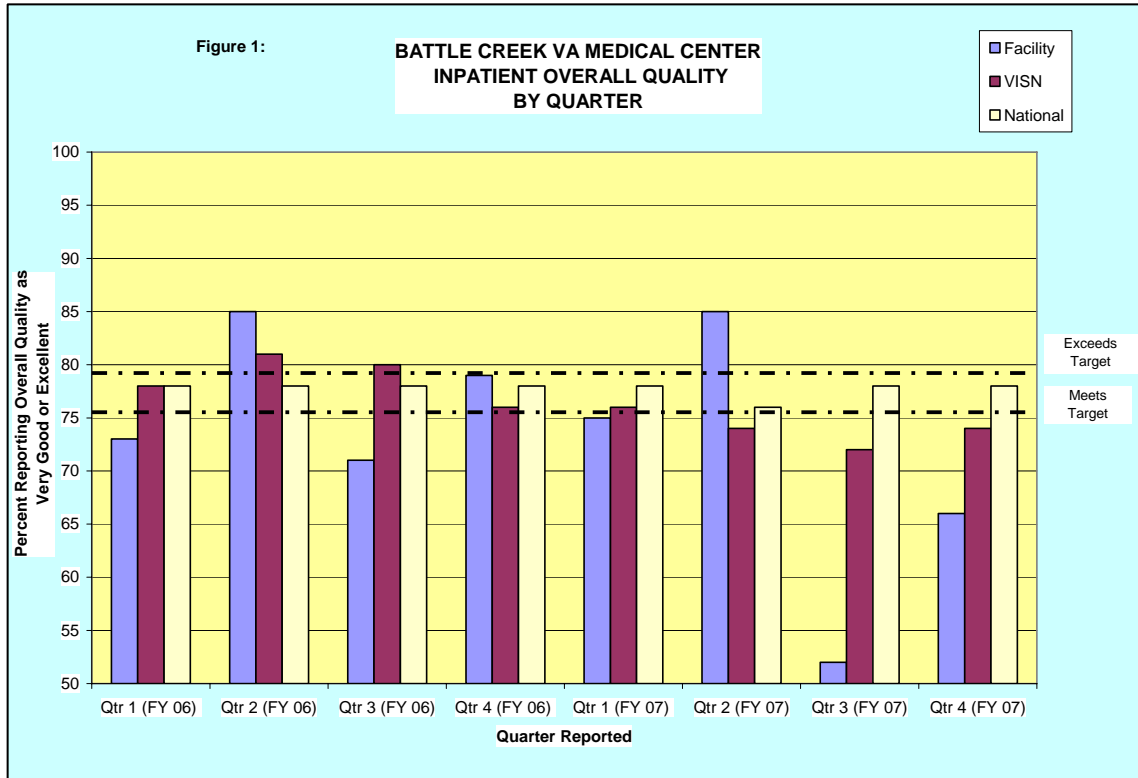
The Acting VISN and Medical Center Directors concurred with the finding and recommendation. Medical center policy will include CPRS business rule requirements, and the Medical Records Committee will complete a quarterly compliance review. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

**Survey of
Healthcare
Experiences of
Patients**

The purpose of this review was to assess the extent that VHA medical centers use the quarterly SHEP survey results to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

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

¹⁰ A patch is a piece of software that can be an upgrade, fix, or update to address new issues, such as security problems.



The medical center's inpatient satisfaction scores were below the established target during 5 of the last 8 quarters of available data. The outpatient satisfaction scores met or exceeded the established target during 7 of the last 8 quarters. Medical center managers have identified opportunities for improvement based on the SHEP survey scores but have not implemented an action plan that has measurable, achievable goals or that identifies who is responsible for the plan. There are three full-time employees dedicated to patient advocacy and patient satisfaction; however, there is no evidence of an ongoing and effective collaborative approach that analyzes, communicates, and addresses suboptimal scores throughout the organization.

Recommendation 11

We recommended that the Acting VISN Director ensure that the Medical Center Director requires implementation of an action plan to improve patient satisfaction that includes measurable goals and assigns responsibility for completion of tasks.

The Acting VISN and Medical Center Directors concurred with the findings and recommendation. A Planetree Coordinator will be hired to improve communication and patient satisfaction. Measurable goals and tasks will be monitored by the Customer Service Oversight Board, the Quality Board, and the Executive Leadership Board and through each service by the dissemination of data and action plans at service-level meetings. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

**Pharmacy
Operations**

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances (CS) and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations¹¹ governing pharmacy and CS security and assessed whether the medical center's policies and practices were consistent with these regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and infection control concerns, and we interviewed Pharmacy Service and Police Service employees. Additionally, we interviewed staff to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. VA policy¹² requires that pharmacy entry doors be mounted with internal hinges or have security measures, such as pins or spot welding, which will prevent removal of the doors from the outside corridors. We found that the inpatient and outpatient pharmacies had entry doors with externally mounted hinges. The Chief of Engineering Service confirmed that both doors were secured with spot welding, in accordance with VA policy.

The medical center had appropriate policies and procedures to ensure pharmacy and CS security. CS inspections were conducted in accordance with VHA regulations. Training records showed that the CS Coordinator and inspectors received appropriate training to execute their duties. The pharmacies' internal environments were clean and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications may result in adverse reactions and increased risk of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.¹³ Some literature suggests

¹¹ VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

¹² VA Handbook 0730/1, *Security and Law Enforcement*, August 20, 2004.

¹³ Yvette C. Terrie, BSPHarm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

that elderly and mental health patients are among the most vulnerable populations for polypharmacy.¹⁴

Managers had a process in place to ensure the regular review of medication regimens for patients prescribed multiple medications. Each patient's medication profile is reconciled in CPRS in accordance with medical center policy.¹⁵ This process monitors medications for inpatients, outpatients, patients monitored through home-based primary care, and patients in the Community Living Center. We made no recommendations.

¹⁴ Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21-23, January 2006.

¹⁵ Medical Center Memorandum No. 11-1113, *Medication Reconciliation*, March 2007.

Acting VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: May 5, 2008

From: Acting Network Director, VISN 11 (10N11)

Subject: **Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan**

To: Director, Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (10B5)

1. Attached is Battle Creek's response to the draft report, Project No. 2008-00399-HI-0034.
2. If you have any questions, please contact Jim Rice, QMO, at 734-222-4314.



Lou Ann Atkins, MSN, MBA, FACHE

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 30, 2008
From: Medical Center Director (515/00)
Subject: **Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan**
To: Acting VISN Director (10N11)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Battle Creek VA Medical Center. We concur with all the findings and recommendations.
2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans. Thank you.

(original signed by:)

TONY ZAPATA, 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 the Acting VISN Director ensure that the Medical Center Director takes action to meet VHA requirements for PRs.

Concur

Target Date: July 1, 2008

The Peer Review (PR) Committee will conduct monthly meetings beginning in May 2008 to focus on completion of backlogged cases and ensure timely completion of all future reviews in accordance with VHA policy. Target completion date of any backlogged cases is July 1, 2008. Of the 19 PRs performed during FY 2007, 4 exceeded 45 days for completion of the initial review, and 9 exceeded 120 days for final evaluation by the committee. These were all completed in November 2007. Monthly meetings will further ensure timely completion of all further reviews.

Minutes from the PR Committee will be presented to the Executive Leadership Board (ELB) monthly beginning in May 2008.

Individual peer reviews will continue to be tracked and trended by rating levels and by changes from one rating level to another. However, actions will now be monitored until completion beginning in May 2008. The monitoring will be recorded on the Quality Management spreadsheet maintained for this purpose, and the monitoring will also be reflected in the PR Committee minutes. In addition, the VISN is currently in the process of collecting peer review data and recording on a VISN maintained spreadsheet.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient complaint data are compared to the SHEP results and that corrective actions are initiated and monitored.

Concur

Target Date: August 1, 2008

The medical center is in the process of hiring a full-time employee to coordinate the implementation of the Planetree Initiative for patient centered care. The target fill date is July 1, 2008. The position will

encompass oversight of the Customer Service Program to include identification of meaningful trends via data comparisons of the patient complaint program to the SHEP scores. Opportunities for improvement will be identified, and corrective actions will be implemented and tracked by the Customer Service Program to ensure improvement in the negative trends identified. Outcomes will be reported monthly to the Quality Board and upward to the Executive Leadership Board. Target date to implement corrective actions in negative trends will begin August 1, 2008, with monthly reporting to follow.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that managers monitor the importing and copying of text in electronic medical records.

Concur

Target Date: May 31, 2008

The Medical Records Committee (MRC) will include an additional specific monitor to the point of care medical records review process beginning in May 2008. This review will include the importing and/or copying of electronic text into the record. The results of these record reviews will be shared with the responsible Service Chief(s) for appropriate action and follow-up reporting on a quarterly basis to the MRC.

Recommendation 4. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that adverse event disclosures are managed in accordance with VHA policy.

Concur

Target Date: June 30, 2008

The "Disclosure of Adverse Events to Patients," Directive 2008-02, requires clinical disclosure within 24 hours and institutional disclosure within 72 hours. Incidents with severity codes of 0 or 1 are forwarded to the applicable ward Social Worker on the day the incident occurs as the Social Worker is a co-signer on the Adverse Event Progress Note. Incidents with severity codes of 2 or 3 are referred immediately to the Chief of Staff's Office for either a clinical or institutional disclosure and are followed by the Risk Manager. The Risk Manager tracks all incidents with severity codes of 0 or 1 on an incident tracking report spreadsheet. The Chief of Staff is responsible for notifying the Risk Manager of incidents with severity codes of 2 or 3 for tracking on the report spreadsheet, which reflects the type of disclosure and when it took place by the Chief of Staff. Peer review and incident report disclosures are tracked by the Risk Manager and reported to the Medical Center Director and to the attendants of the daily leadership meeting. The Chief of Staff will ensure that all institutional disclosures are documented using the electronic disclosure template in CPRS. For clinical disclosures, an electronic template will be created and implemented by June 2008 for the disclosure

of all necessary information to the patient. The template will be similar to Attachment B in the Disclosure Directive.

Recommendation 5. We recommended that the Acting VISN Director ensure that the Medical Center Director conducts an independent review of the two patients identified during our inspection as having experienced adverse events to ensure that VHA policy is followed.

Concur

Target Date: May 30, 2008

The Chief of Staff's Office will ensure that the disclosures are completed and appropriately documented in accordance with VHA policy.

Recommendation 6. We recommended that the Acting VISN Director ensure that the Medical Center Director takes action to strengthen communication and collaboration between UM, MCCR, and fee basis staff.

Concur

Target Date: June 30, 2008

The following actions have taken place since March 2008, which will effectively strengthen communication and collaboration between Utilization Management (UM), Medical Care Cost Recovery (MCCR), and fee basis staff:

- A MCCR Utilization Review Nurse position vacancy was filled. The MCCR Utilization Nurse completed training provided by an expert consultant from the VAMC in Indianapolis, IN.
- Staff from UM, Medical Administration Service (MAS), and MCCR were all in attendance and participated at the recent monthly UM Committee meeting.
- In April 2008, UM, MAS, and MCCR Utilization Review Nurses completed a two-week McKesson's InterQual training session.
- In April 2008, the Utilization Management Section oversight was transferred from Ancillary Services to Quality Resources Service, with plans to hire three additional Utilization Management Nurses. Interviews for these positions will take place in May 2008.
- In June 2008, the UM, MAS, and MCCR Utilization Review Nurses will establish criteria for the creation of monthly reports, which will be utilized to identify and monitor problem areas, initiate corrective actions, facilitate educational opportunities for multidisciplinary staff, and ensure an effective UM program for third-party reimbursement.

Recommendation 7. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that infection control vulnerabilities identified during the onsite review be corrected.

Concur

Target Date: July 1, 2008

Plastic emergency call system cords have been ordered and will be fully installed to replace the existing rope-style cords, including the light pull cords, by June 30, 2008. The new cords will also provide accessibility from the floor.

Logs for monitoring refrigerator temperatures were modified in March 2008 to include the optimum temperature range and an area for recording action(s) taken if the temperature was outside the required range. In May 2008, a remote electronic monitoring system will be installed, which will monitor all medication and nourishment refrigerators in Battle Creek and its associated CBOCs. Appropriate personnel in various departments will be notified when a refrigerator temperature is out of range so that immediate action can be taken. There will be a continual record of temperatures available for each refrigerator. In addition, Quality Management and Infection Control staff conducted rounds on all wards on May 2, 2008, to inspect the condition of refrigerator door seals to insure they are intact and clean. All identified cracked and dirty seals on medication and nourishment refrigerators will be corrected by July 1, 2008. In addition, several new refrigerators have been ordered to replace those in need of replacement.

Leadership rounds inspect all areas of the medical center and its associated CBOCs semi-annually. MCM Policy 138-1011, "Interior Design Responsibilities and Procedures," allows addressing furniture needs by sending an e-mail to G.Furniture with Service Chief approval/concurrence. Some replacement furniture was ordered in April 2008. Other specialty items are in the process of being built (prototypes) and will be evaluated for suitability in the acute care environment. Purchase orders for patient care equipment are reviewed and prioritized for purchase by the Resource Management Committee.

Wards served by area maintenance can enter a request in the ward work book. All other areas enter electronic work orders. Facilities Management Service is assuring that all Service Secretaries and Ward Secretaries have appropriate access to the electronic work order menus.

Staff is required to complete an annual Learning Management System (LMS) module regarding the reporting and processing of equipment, furniture, etc., that is identified as compromised. Further training will also be included in monthly Environmental Management Service (EMS) and Nursing Service staff meetings to enhance staff awareness of their

responsibility to identify and appropriately report findings of compromised surfaces on items, such as mattresses, chairs, wheelchairs, tray tables, etc., which prevents the effective cleaning thereof. Documentation will be recorded in the applicable Service staff meeting minutes on an ongoing basis.

Damaged ceiling tiles will be reported by the ward through the work order system so that Facilities Management Service staff can take the appropriate action to replace damaged ceiling tiles. Damaged ceiling tiles are also identified on environmental leadership rounds and reported and followed up to ensure corrective action has been taken.

Recommendation 8. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that safety vulnerabilities identified during the onsite review be corrected.

Concur

Target Date: July 1, 2008

Individual ceiling panels used in the hallways of the locked mental health units will be checked to ensure safety clips are in place to restrict removal of the panels, with a targeted completion date of May 15, 2008, or sooner. Sprinkler system installation was recently completed on the locked mental health units, which may have been the cause of a panel not being appropriately clipped.

As of March 2008, all dirty linen receptacles are being placed in the patient locked shower room on the locked mental health units. Weekly rounds have ensured that this practice is being followed.

At this time, no product is available to replace the shower control fixtures that could not be used as an anchor point. Facilities Management Service is researching whether a metal fabrication firm will be able to produce a valve box, which will lock the shower control fixtures in the women's shower room on the locked geriatric and long-term mental health unit. The targeted completion date is July 31, 2008. To minimize incidents, staff safety rounds are made every 15 minutes. Acutely ill psychiatric patients are placed on 1:1 observation.

The c-tub hose can be removed when not in use but must be unscrewed. The hose is difficult to disconnect manually. However, the hoses have now been disconnected and completely removed. This area is only available to patients with staff supervision. A decision regarding removal or non-removal of c-tubs from the area will be ascertained by July 1, 2008.

Splintered doors throughout the dementia unit will be repaired by June 2008. A larger project to replace these doors has been approved for FY 2009.

Oxygen tank holders are present for both clean and used oxygen tanks on the acute care ward. On the day of the survey, an empty tank was found in the clean oxygen area and not in a holder. The tank was immediately moved to a holder in the used tank area. Nursing staff were advised by the Nurse Manager of the proper storage of oxygen tanks.

Recommendation 9. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that patient privacy vulnerabilities identified during the onsite review be corrected.

Concur

Target Date: August 1, 2008

Patient privacy vulnerabilities have been corrected, e.g., removal of clipboards in corridors and white boards in nurse's office. Management will continue to assess vulnerabilities during weekly rounds.

In April 2008, all patient identifying information was removed from the bedside and secured at the nursing stations. A new electronic caretracker system will be in place by August 2008, which will optimize patient privacy by reducing hard copy availability.

Recommendation 10. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance.

Concur

Target Date: June 30, 2008

CPRS business rules were corrected for immediate compliance by limiting the ability to amend signed discharge summaries to the Privacy Officer (exercised only pursuant to the regulatory amendment process). Recommendation will be made to the Medical Records Committee in May 2008 to adhere the CPRS business rules to the MCM Policy 11-1101, "Medical Records Documentation Standards and Requirements for Completion and Timeliness."

The Medical Records Committee will complete a quarterly review of CPRS business rules, and the first report will be due to the CEB in June 2008.

Recommendation 11. We recommended that the Acting VISN Director ensure that the Medical Center Director requires implementation of an action plan to improve patient satisfaction that includes measurable goals and assigns responsibility for completion of tasks.

Concur

Target Date: July 31, 2008

Patient satisfaction will be improved through the implementation of the Planetree Initiative. Please reference response to Recommendation 2 also. The addition of a Planetree Coordinator (planned for June 2008) will

provide oversight for this plan, which fosters and prioritizes patient comfort, safety, dignity, empowerment, and well-being. The Coordinator for this initiative will oversee the Customer Service Program and work closely with all aspects of patient care at the medical center and its associated CBOCs to improve communication and patient satisfaction. The action plans will encompass inpatient and outpatient satisfaction. Measurable goals and tasks will be monitored through the Customer Service Oversight Board, the Quality Board, the Executive Leadership Board, and ultimately through each Service by the dissemination of data and action plans at each of the respective Service meetings. Implementation of this recommendation is targeted for July 2008.

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