



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

**Office of Healthcare Inspections**

**Report No. 07-03176-17**

# **Combined Assessment Program Review of the Togus VA Medical Center Augusta, Maine**



**November 3, 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 September 8–12, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Togus VA Medical Center (the medical center), Augusta, ME. 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 for 92 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 1.

### Results of the Review

This CAP review covered eight operational activities. We also followed up on one review area from the July 2005 CAP review. We identified the following organizational strengths and reported accomplishments:

- Improved access to outpatient care.
- Improved access to inpatient care.
- Recipient of the 2008 VISN 1 award for the greatest improvement in employee satisfaction.

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

- Analyze provider performance data as part of the reprivileging process.
- Ensure that Professional Standards Board (PSB) minutes reflect all pertinent activity and are approved by the Director.
- Ensure that Peer Review Committee (PRC) minutes reflect all pertinent peer review activity and are distributed and approved by the committee.
- Ensure that the PRC reviews mortality cases that meet criteria and reports peer review activity quarterly to the Medical Executive Committee (MEC).
- Ensure that clinical managers monitor the use of reversal agents for moderate sedation.
- Validate the security of blank prescription pads.
- Monitor and record temperatures for medication and patient nutrition refrigerators daily.

- Improve security in the Emergency Department (ED) and in the ED triage area.
- Ensure that discharge summaries are completed, discharge instructions are consistent with discharge summaries, and patients receive discharge instructions.
- Document pain reassessments within the appropriate timeframes and document the actions taken if medications are ineffective.
- Ensure that nurses scan patients' wristbands prior to medication administration.

The medical center complied with selected standards in the following two activities:

- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Katherine Owens, Director, Bedford 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 15–20 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 Augusta, ME, and provides a broad range of inpatient and outpatient health care services. It also provides outpatient services at six community based outpatient clinics (CBOCs) in Bangor, Calais, Caribou, Lincoln, Rumford, and Saco, ME, and has a mental health (MH) clinic in Portland, ME. The medical center is part of VISN 1 and serves a veteran population of approximately of 145,000.

**Programs.** The medical center is a primary and secondary health care facility and provides comprehensive health care services in medicine, surgery, psychiatry, and long-term care.

**Affiliations and Research.** The medical center is affiliated with the Massachusetts Eye and Ear Infirmary in Boston, MA, and provides training for residents in ophthalmology. It also serves as a training site for students in psychiatry, clinical psychology, dentistry, and nursing. The medical center is in the process of developing a full-time research program.

**Resources.** In fiscal year (FY) 2007, the medical center's medical care budget totaled approximately \$145 million. For FY 2008, the medical care budget was approximately \$164 million. FY 2008 staffing was 1,162 full-time employee equivalents (FTE), including 80 physician and 370 nursing FTE.

**Workload.** During FY 2007, the medical center treated approximately 38,000 unique patients and provided inpatient care to more than 1,300 patients. It had 67 operating hospital beds with an average daily census (ADC) of 44 and 100 operating community living center (CLC)<sup>1</sup> beds with an ADC of 61. Outpatient workload for FY 2007 totaled over 332,000 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:

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<sup>1</sup> A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- 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 eight activities:

- Coordination of Care.
- ED/Urgent Care Clinic (ED/UCC).
- Environment of Care (EOC).
- Medication Management.
- Pharmacy Operations.
- QM Program.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and quarters 1 and 2 of FY 2008 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the Togus VA Medical Center, Togus, Maine, Report No. 05-01608-85, February 8, 2006*). In that report, we identified improvement opportunities in radiology timeliness. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the identified deficiencies, and we consider those issues closed.

During this review, we presented fraud and integrity awareness briefings for 92 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 made 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 Strengths

### **Improved Access to Outpatient Care**

The medical center initiated processes that increased access to outpatient care by improving the use of medical center and community resources for specialty clinic appointments, enhancing clinic staffing, and educating staff about appointment scheduling. As a result, between October 2007 and September 2008, the number of patients waiting over 30 days for clinic appointments decreased from more than 2,600 to less than 200.

### **Improved Access to Inpatient Care**

In February 2007, the medical center’s average length of stay for acute medicine beds was over 11 days. The medical center implemented strategies that improved discharge planning and helped reduce delays in patient discharges. These efforts improved access to inpatient care, and at the time of our CAP review, the average length of stay on acute medicine had been reduced to approximately 5.4 days.

### **Employee Satisfaction Award**

Medical center senior managers implemented strategies to improve communication between leadership and employees and between leadership and patients. As a result, the medical center’s All Employee Survey results improved, and the medical center received the 2008 VISN 1 “Greatest Improvement in Employee Satisfaction” award.



## Results

### Review Activities With Recommendations

#### Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator. The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified areas that needed improvement.

Provider Performance Monitoring. Veterans Health Administration (VHA) regulations<sup>2</sup> and The Joint Commission (JC)<sup>3</sup> require that clinical managers develop plans for continuous performance monitoring for the medical staff. According to the requirements, performance data should be ongoing, include indicators for continuing qualifications and competencies, and be reviewed and considered during the reprivileging process.<sup>4</sup> At the time of our visit, clinical leaders had completed the credentialing and privileging (C&P) training modules, and plans for ongoing physician competency monitoring had been developed. We reviewed C&P folders and corresponding PI data for 18 providers repriviledged in the past 12 months. We found that 11 of the 18 providers had inadequate data for the privileges granted.

Professional Standards Board Minutes. We found that there were no approved PSB minutes available from April–August 2008. The role of the PSB is to review relevant provider information, document discussions, and make recommendations associated with the requested clinical privileges. The outcomes of the discussions are to be recorded in the PSB minutes and then reviewed and approved by the Chair of the PSB, the Chief of Staff, and the medical center's Director. VHA regulations<sup>5</sup> delineate that

<sup>2</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

<sup>3</sup> The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, January 2007, MS.4.40.

<sup>4</sup> The process of evaluating professional credentials and clinical competencies of practitioners who hold clinical privileges at the facility.

<sup>5</sup> VHA Handbook 1100.19.

facility Directors have ultimate responsibility for C&P. The medical center's Director should have the benefit of reviewing PSB minutes prior to approving clinical privileges.

Peer Review. VHA regulations<sup>6</sup> require that the PRC document peer review activity. The documentation (typically in PRC minutes) should reflect the rationale for changes in levels of care, indicate that providers with peer reviews designated at levels 2 and 3<sup>7</sup> were invited to respond to PRC findings, and show that identified improvement actions were implemented.

The PRC met at least quarterly, as required; however, PRC minutes did not consistently reflect the required aspects of the peer review process. We also found that PRC minutes were not consistently distributed for review and approval. Additionally, we found that the PRC did not review mortalities that met criteria for peer review, as required. Mortalities were instead reviewed as part of the morbidity and mortality process. Also, the PRC did not report peer review activity quarterly to the MEC.

Moderate Sedation. While clinical managers monitored outcomes of moderate sedation, we did not find evidence that they monitored the use of reversal agents,<sup>8</sup> as required by VHA regulations.<sup>9</sup>

**Recommendation 1** We recommended that the VISN Director ensure that the Medical Center Director requires that provider PI data are collected and analyzed as part of the reprivileging process for all providers.

**Recommendation 2** We recommended that the VISN Director ensure that the Medical Center Director requires that PSB minutes reflect all required elements and that they are forwarded to the Director for review and approval.

**Recommendation 3** We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes reflect the required elements of the peer review process and that the minutes are distributed for review and approval.

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<sup>6</sup> VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

<sup>7</sup> Level 2 indicates that most experienced, competent practitioners might have managed the case differently. Level 3 indicates that most experienced, competent practitioners would have managed the case differently.

<sup>8</sup> Reversal agents are medications used to counteract the effects of sedation.

<sup>9</sup> VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

**Recommendation 4** We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC review mortalities that meet criteria and report peer review activity quarterly to the MEC.

**Recommendation 5** We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers include the use of reversal agents when monitoring moderate sedation outcomes.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that clinical managers initiated a revision of the privileging forms and the reporting format to extract provider PI data. The template for PSB minutes has been revised to include all required elements, and the minutes will be forwarded to the Director for review. They also reported that PRC minutes will include all required elements and be distributed timely. The PRC will review all mortalities that meet criteria and report peer review activity quarterly to the MEC. Additionally, clinical managers revised the moderate sedation monitoring form to include the use of reversal agents. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## **Pharmacy Operations**

The purposes of this review were to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances (CS) and pharmacies' internal physical environments and whether clinical managers had processes to monitor inpatient and outpatient medication use to avoid polypharmacy in vulnerable populations, such as the elderly and MH patients.

Pharmacy Controls. We reviewed VHA regulations<sup>10</sup> governing pharmacy and CS security, and we assessed whether the medical center's policies and processes were consistent with VHA regulations. We reviewed the CS inspection program and inspected inpatient and outpatient pharmacies for security, EOC, and infection control issues. In addition, we interviewed CS inspectors and appropriate Pharmacy Service and Police and Security Service managers. Our review showed that the medical center's CS

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<sup>10</sup> 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.

inspection program was well organized and managed. However, we found that CS inspectors did not validate pharmacy controls over blank prescription pads, as required by VHA regulations.<sup>11</sup>

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks 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.<sup>12</sup> Some literature suggests that elderly patients and MH patients are among the most vulnerable populations for polypharmacy.<sup>13</sup>

We interviewed pharmacy clinical managers to determine the medical center's efforts to monitor and avoid inappropriate polypharmacy. Clinical pharmacists identified patients who were prescribed multiple medications, reviewed the patients' medication regimens to avoid complications related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate.

## **Recommendation 6**

We recommended that the VISN Director ensure that the Medical Center Director requires that CS inspectors validate the security of blank prescription pads stored in the pharmacies.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that managers added the validation of blank prescription pad security to the CS inspectors' checklist. Inspectors will begin using the revised checklist the week of October 13, 2008. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

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<sup>11</sup> VHA Handbook 1108.2.

<sup>12</sup> Yvette C. Terrie, BSPHarm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

<sup>13</sup> 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.

## Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards. We inspected the following areas: (a) two CLCs (b) one medical unit, (c) one surgical unit, (d) the same day surgery area, (e) the outpatient dialysis unit, (f) the specialty care unit, (g) acute MH, (h) the dental clinic, (i) primary care, (j) the inpatient and outpatient pharmacies, (k) the women's clinic, and (l) the Saco CBOC.

The areas we inspected were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their units. Additionally, we inspected the acute inpatient MH unit to determine if managers identified environmental hazards that potentially posed threats to patients and to ensure that staff received specialized training. The medical center provided documentation of risk assessment and abatement tracking of safety issues previously identified on the MH unit, and we found that suicide risk training was completed. However, we identified one area that needed improvement.

Safety. We found that temperature logs for two patient nutrition refrigerators and the medication refrigerator on one CLC showed that temperatures were not monitored and recorded on a daily basis, as required by medical center policy.<sup>14</sup> Appropriate temperature controls ensure the safety of food items and maintain the efficacy of medications.

## Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director requires nursing personnel to monitor and record temperatures in medication and nutrition refrigerators daily.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the Nursing Procedure Committee drafted a procedure specific to nutrition and medication refrigerator temperature monitoring. Nurse managers will monitor compliance with

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<sup>14</sup> Togus VA Medical Center Nursing Procedure 118P-03-1, *Digital Thermometer Recording*, March 3, 2006.

the procedure. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

## **Emergency Department/Urgent Care Clinic**

The purpose of this review was to evaluate selected aspects of clinical services, staff competencies, and operations in VHA ED/UCCs. We also determined whether the physical environment was clean and safe and whether managers maintained equipment appropriately. The medical center did not have a UCC but did have an ED that operated 7 days a week, 24 hours a day.

We interviewed ED managers and the clinicians involved in managing patient inter-facility transfers. We reviewed policies and other pertinent documents, including equipment maintenance records. Additionally, we reviewed medical records of patients who had consults to other services and who were transferred from the ED to other medical facilities. Our review showed that consults, transfers, and staff competencies were appropriate. We found that the area was clean and that managers appropriately maintained equipment. However, we identified one area that needed improvement.

Security. The JC requires that the medical center identify and manage its security risks.<sup>15</sup> At the time of our CAP review, access to the ED was unrestricted because entry doors to the area could not be locked. ED managers reported that they had ordered keypad locks but that the locks had not yet arrived. Additionally, the ED triage area was separated from the patient waiting area by a low counter that could easily be breached, and there was no duress alarm available for employees to summon help if needed. Triage area employees recently expressed concerns to management about their safety, particularly when patients waiting for ED services become agitated or aggressive.

## **Recommendation 8**

We recommended that the VISN Director ensure that the Medical Center Director requires the installation of locks on ED doors and the improvement of security in the triage area.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that Facility Management Service managers contracted for the installation of locks on the ED entry doors and completed construction of a “safe” room in the ED for monitoring

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<sup>15</sup> The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, September 2007, EC.2.10.

agitated patients. They also reported that plans are in place to add a duress alarm in the triage workstation area. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## **Coordination of Care**

The purpose of this review was to evaluate whether VHA facilities had adequate processes to ensure coordination of care across the continuum of patient services. We reviewed three aspects of care: (a) patient consults, (b) patient intra-facility transfers, and (c) patient discharges. We found that providers managed patient consults and intra-facility transfers appropriately. However we identified one area that needed improvement.

Patient Discharges. We reviewed medical record documentation for 12 patients discharged from inpatient care, and as part of the ED review, 2 MH patients discharged from the ED. We found documentation deficiencies in nine of the records reviewed. One inpatient record had no discharge summary, and inconsistencies between discharge summaries and patient discharge instructions existed in five other inpatient records. VHA regulations<sup>16</sup> require that discharge summaries be completed prior to discharge and that specific information be included in discharge summaries and instructions. Additionally, three records did not have documentation to support that the patients received discharge instructions at the time of discharge from the medical center (one from inpatient care and the two from the ED). Medical center policy<sup>17</sup> requires that clinicians provide written discharge instructions to all patients.

## **Recommendation 9**

We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries are completed, that discharge instructions are consistent with discharge summaries, and that patients receive written discharge instructions.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the Chief of Staff will send a memorandum re-educating providers about the facility's requirements. ED clinical managers will research computer software applicable to the ED to provide standardized discharge instruction documentation. The

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<sup>16</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

<sup>17</sup> Togus VA Medical Center Circular 00-03-81(11), *Admission and Discharge Planning*, September 2003.

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management processes to ensure safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes on inpatient units, and we interviewed nurse managers and other nursing staff. Additionally, we observed nurses administering medications, and we asked patients if nurses scanned their wristbands prior to administering their medications.

We found adequate management of medications brought into the facility by patients or their families. Additionally, we found that the processes for reconciling CS discrepancies at the unit level were adequate. However, we identified two areas that needed improvement.

Pain Medication Effectiveness. VHA regulations<sup>18</sup> and the JC<sup>19</sup> require that clinicians monitor PRN<sup>20</sup> medications for effectiveness. Additionally, medical center policy governing pain management requires that pain reassessments occur 30–60 minutes after each pain management intervention.<sup>21</sup> We reviewed 124 administered doses of PRN pain medications and found that pain reassessments were not consistently documented within the required timeframe. Additionally, we found that clinicians did not consistently document appropriate actions taken if the pain medications proved ineffective.

Medication Administration. The medical center's Bar Code Medication Administration (BCMA) policy requires that nurses scan patients' wristbands prior to medication administration.<sup>22</sup> This practice correctly identifies patients and reduces medication errors. We found that staff scanned patient wristbands prior to medication administration on all units except one. On that unit, we observed that a nurse did not scan the wristband of a patient. The nurse explained that the wristband was not scanned because the patient was in isolation. However, BCMA policy outlines the process to

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<sup>18</sup> VHA Directive 2003-021, *Pain Management*, May 2, 2003.

<sup>19</sup> The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, January 2007, MM-15.

<sup>20</sup> PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as the circumstances require.

<sup>21</sup> Togus VA Medical Center Circular 00-05-08(11), *Pain Management*, February 15, 2005.

<sup>22</sup> Togus VA Medical Center Nursing Procedure 118P-08-4, *Bar Code Medication Administration (BCMA) Procedure*, March 7, 2008, p. 4.



use when scanning wristbands of patients who are in isolation.<sup>23</sup> In addition, another patient stated that nurses did not consistently scan his wristband prior to each medication administration. The nurse manager acknowledged that scanning patients' wristbands was not consistently performed.

**Recommendation 10** We recommended that the VISN Director ensure that the Medical Center Director requires documentation of pain reassessments within appropriate timeframes and the documentation of actions taken when medications are ineffective.

**Recommendation 11** We recommended that the VISN Director ensure that the Medical Center Director requires that nurses scan all patients' wristbands prior to medication administration and that compliance with this requirement is monitored.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that the Nursing Procedure Committee is revising the medical center's current policy and expects approval in November 2008. They also reported that the PRN effectiveness report is being run at the end of each shift and is reviewed it for appropriate documentation. Additionally, nurse managers anticipate the availability of the BCMA software enhancement that will report and track failures to scan wristbands by the end of December 2008. In the meantime, the BCMA Coordinator is conducting random observations to monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Review Activities Without Recommendations

### Staffing

The purpose of this review was to evaluate whether VHA facilities developed comprehensive nurse staffing guidelines and whether the guidelines were met. We reviewed nurse staffing documents for all inpatient units, including the intensive care unit, and interviewed nurse managers. We found the staffing methodology to be appropriate. We made no recommendations.

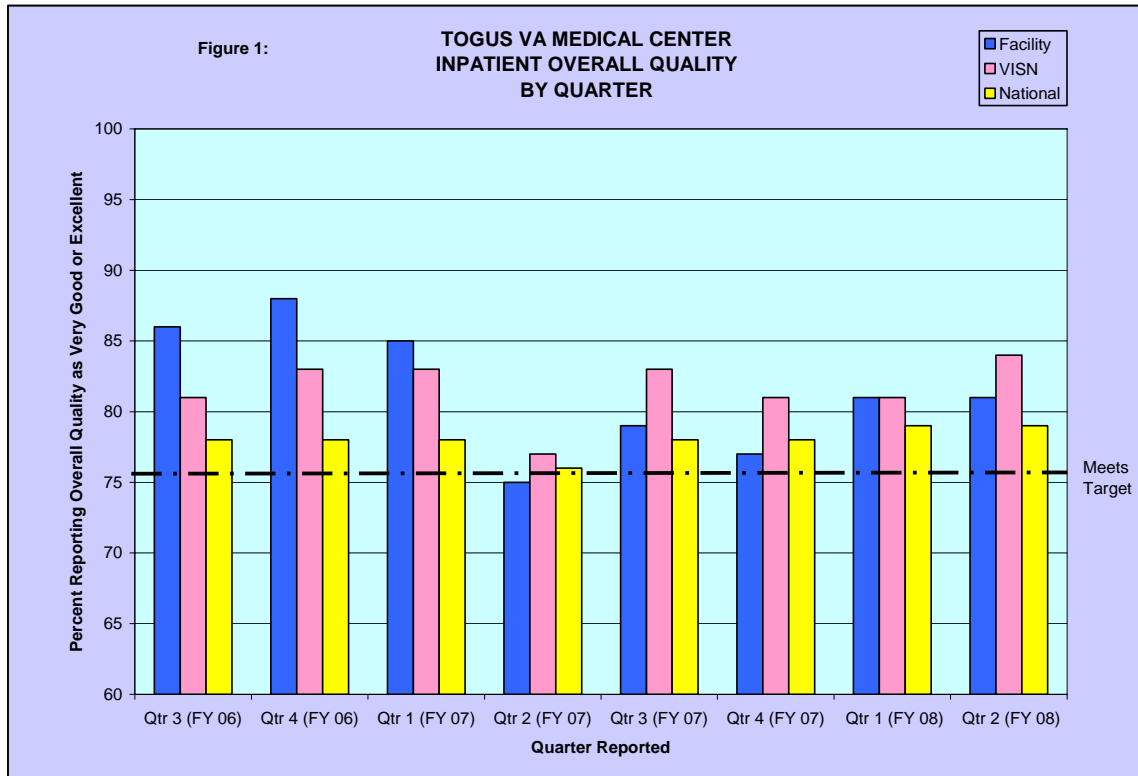
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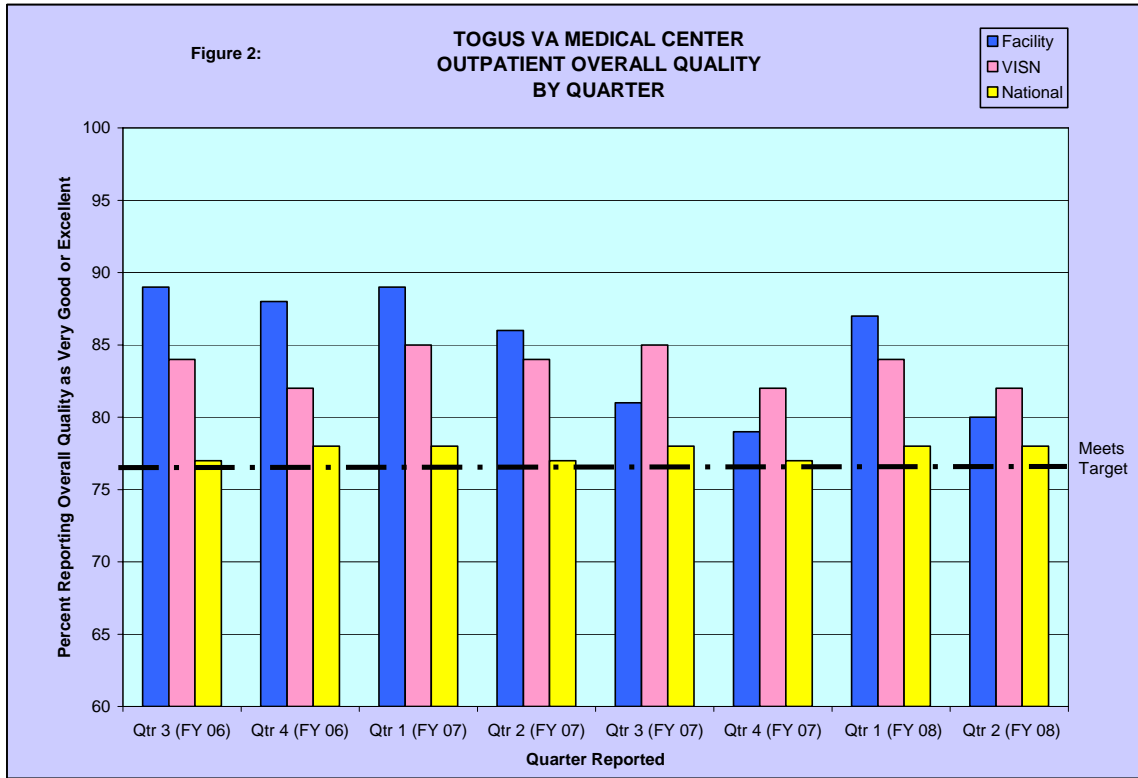
<sup>23</sup> Ibid., p. 5.

## Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities use quarterly or semi-annual SHEP results to improve patient care 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 goals for patients reporting overall satisfaction of “very good” or “excellent” at 76 percent for inpatients and 77 percent for outpatients.

We reviewed survey results for quarter 3 of FY 2006 through quarter 2 of FY 2008. The medical center’s inpatient results met or exceeded the target in 7 of the 8 quarters reviewed. The medical center’s outpatient results exceeded the target in all eight quarters reviewed. Findings are displayed in the graphs below and on the next page.





Medical center managers analyzed their survey results, developed improvement strategies, and monitored the results of the action plans. Survey results and improvement strategies were disseminated throughout the organization. We made no recommendations.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** October 9, 2008

**From:** Director, VA New England Healthcare System (10N1)

**Subject:** **Combined Assessment Program Review of the Togus  
VA Medical Center, Augusta, Maine**

**To:** Director, Bedford Office of Healthcare Inspections (54BN)  
Director, Management Review Service (10B5)

I have reviewed the findings and Recommendations and concur. Our actions to the Recommendations are attached. For further information, please contact the VISN 1 QMO.

*(original signed by:)*

**MICHAEL MAYO-SMITH, MD, MPH**

VISN 1 Network Director

## Medical Center Director Comments

Department of  
Veterans Affairs

Memorandum

**Date:** October 7, 2008

**From:** Director, Togus VA Medical Center (402/00)

**Subject:** **Combined Assessment Program Review of the Togus VA Medical Center, Augusta, Maine**

**To:** Director Bedford Office of Healthcare Inspections (54BN)  
Director, Management Review Service (10B5)

We concur with the findings and the eleven recommendations presented in the Togus VA Medical Center OIG CAP Review. Comments to the report on the following pages comprise a brief implementation plan and target completion date to address each recommendation.

The organization benefited from the thorough review of our operations, systems, and processes as well as from the inherent helpful, consultative nature of the team members interactions with staff.

The goal to provide excellent quality of health care for the veterans of Maine is, of course, always in our sights as we dedicate our efforts and resources every day.

Questions or further comments regarding this response can be directed to me with the anticipation of a complete and timely reply. Thank you.

*(original signed by:)*

Brian G. Stiller

Director, Togus VA Medical Center

## 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 requires that provider PI data are collected and analyzed as part of the reprivileging process for all providers.

Concur – Target Completion Date: December 31, 2008

A revision of the privileging forms and the reporting format to extract PI data from various facility databases has been initiated by the COS Office. When rolled out to the Clinical Service Chiefs, the data will be utilized in the review and consideration for each individual during the reprivileging process.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires that PSB minutes reflect all required elements and that they are forwarded to the Director for review and approval.

Concur – Completion Date: September 30, 2008

Effective September 30, 2008, the template for PSB minutes has been changed to include all required elements. Minutes are forwarded to the Center Director for review and approval and to assist in the reprivileging decision. Request recommendation be closed.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director requires that PRC minutes reflect the required elements of the peer review process and that the minutes are distributed for review and approval.

Concur – Target Completion Date: October 27, 2008

The PRC Chair has directed the recorder to include the required elements of the peer review process in all subsequent minutes and electronically distribute them to members prior to each meeting. All FY 2008 meeting minutes have been distributed reviewed and approved by the PRC. The Peer Review Committee will formally address the recommendation at the

October meeting to ensure members are made aware of their responsibility to respond if minutes are not provided accordingly.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC review mortalities that meet criteria and report peer review activity quarterly to the MEC.

Concur – Completion Date: August 1, 2008

In accordance with VHA Directive 2008-004, Peer Review, all mortalities that meet criteria for peer review are now identified using the occurrence screen by the Quality Management Specialist and directed to the Peer Reviewer through the protected Peer Review notification process by the Quality Manager. Quarterly report of the Peer Review activity by the Chair, PRC has been added as a standard agenda item to the Clinical Executive Board. The first of these having been reported at the September 11, 2008 meeting. Request recommendation be closed.

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers include the use of reversal agents when monitoring moderate sedation outcomes.

Concur – Target Completion Date: December 1, 2008

The form on which moderate sedation is documented has recently been modified to specifically include the use of a reversal agent. The Chief, Surgical Service, has put a process in place to receive and review the forms from the three services in which moderate sedation occurs. He will report the results to the Invasive Procedure Committee.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that CS inspectors validate the security of blank prescription pads stored in the pharmacies.

Concur – Target Completion Date: October 31, 2008

The validation of the security of blank prescription pads has been added to the required elements for review on the CS inspector's checklist. Utilization of the revised checklist by the inspectors will commence with inspections the week of October 13, 2008. The Controlled Substance Coordinator (CSC) will monitor the results and include any discrepancies in her report so appropriate investigation/actions can be taken.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director requires nursing personnel to monitor and record temperatures in medication and nutrition refrigerators daily.

Concur – Target Completion Date: November 28, 2008

The Nurse Executive directed action to be taken. Nursing Procedure Committee has reviewed and drafted the facility Nursing Procedure 118-08-13. Approval of draft is anticipated at the November 12th meeting. Specific documentation on a check sheet of the nutrition and medication refrigerators and action taken on any variation outside of range is now required. Once approved by the committee and circulated, the Nurse Managers will monitor the compliance and accountability.

**Recommendation 8.** We recommended that the VISN Director ensure that the Medical Center Director requires the installation of locks on ED doors and the improvement of security in the triage area.

Concur – Target Completion Date: November 28, 2008

Chief, Facility Management Service, has placed the request for procurement and contracted out the installation of locks on entry doors to the area. A “safe” room has also recently been added in the ED to provide a safe environment for both staff and patient. In addition to the duress alarms in the nurse’s station and life support room, plans are in place for one to be installed in the triage work station area.

**Recommendation 9.** We recommended that the VISN Director ensure that the Medical Center Director requires that discharge summaries are completed, that discharge instructions are consistent with discharge summaries, and that patients receive written discharge instructions.

Concur – Target Completion Date: October 31, 2008 for Action 1 and December 31, 2008 for Action 2

Action 1 – The COS is sending a memorandum re-educating the clinical providers on the facility policy as stated above.

Action 2 – The Chief, Medicine Service, and the ED Director are currently consulting colleagues and pursuing possible software applications for discharge instruction, e.g., Logicare, applicable to the ED to provide useful, standardized discharge instruction documentation.

**Recommendation 10.** We recommended that the VISN Director ensure that the Medical Center Director requires the documentation of pain reassessments within appropriate timeframes and the documentation of actions taken when medications are ineffective.

Concur – Target Completion date: November 28, 2008

The Nurse Executive directed action on this recommendation. The Nursing Procedure Committee researched references for guidance on more appropriate time frames. The current policy is being reworked with attention to the time range, anticipating a draft for approval at the



November meeting. The prn effectiveness report is being run at the end of each nursing shift on all nursing units and reviewed for appropriate documentation.

**Recommendation 11.** We recommended that the VISN Director ensure that the Medical Center Director requires that nurses scan all patients' wristbands prior to medication administration and that compliance with this requirement is monitored.

Concur – Target Completion Date: December 31, 2008

The BCMA software enhancement, Managing Scanning Failures, is anticipated to be launched by the end of December, 2008. Reporting and tracking of failures to scan the wristband will be possible. Following the training of the BCMA Coordinator by Nov. 5, facility end user training will be scheduled. The BCMA Coordinator is conducting random observations to monitor the nursing staff compliance while passing medication, re-educating and reinforcing procedure with individuals as needed. Any issues with repeat non-compliance to procedure are brought to the supervisor's attention for further action.

## **OIG Contact and Staff Acknowledgments**

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