Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02559-50

Combined Assessment Program Review of the White River Junction VA Medical Center White River Junction, Vermont

December 30, 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 October 20–24, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the White River Junction VA Medical Center (the medical center), White River Junction, VT. 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 41 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 two review areas from the August 2005 CAP review. We identified the following organizational strengths and reported accomplishments:

- Recipient of the 2008 Robert W. Carey Circle of Excellence Award.
- Recipient of the 2008 Hospitals and Health Networks (H&HN) award for use of information technology.
- Improved hypertension control for outpatients.

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

- Collect and analyze provider performance data and use the information during reprivileging.
- Grant privileges that are consistent with providers' practices.
- Ensure that Peer Review Committee (PRC) minutes reflect that recommended actions items are implemented and ensure that the PRC reports quarterly to the Clinical Executive Board (CEB).
- Ensure that clinical managers monitor corrective actions and implement a plan to monitor anticoagulation therapy.
- Ensure that clinicians discuss adverse events with patients and document the discussions in the medical records.
- Document pain reassessments within appropriate timeframes.

- Ensure that nurses scan all patients' wristbands prior to medication administration.
- Ensure that Emergency Department (ED) registered nurses (RNs) demonstrate required competencies annually and that compliance is documented.
- Ensure that discharge instructions are consistent with discharge summaries and that patients receive written discharge instructions.
- Maintain appropriate medication storage temperatures and minimize security and infection control (IC) risks in the inpatient pharmacy.

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

- Environment of Care (EOC).
- 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 Acting Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–21, 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 White River Junction, VT, and provides a broad range of inpatient and outpatient health care services. It also provides outpatient services at four community based outpatient clinics in Bennington, Colchester, and Rutland, VT, and in Littleton, NH. The medical center is part of VISN 1 and serves a veteran population of approximately of 94,000.

Programs. The medical center is a primary and secondary health care facility and provides comprehensive health care services in medicine, surgery, and mental health (MH).

Affiliations and Research. The medical center is affiliated with Dartmouth Medical School and with the University of Vermont's College of Medicine. More than 200 residents rotate through the medical center annually. The medical center also provides training in nursing and other health care professions, such as psychology, optometry, social work, and physical and occupational therapy.

The medical center has a diverse research program with an annual budget approaching $6 million. It has approximately 114 projects and 51 investigators. Major areas of research include stress and brain trauma, Alzheimer's disease, and autoimmune diseases.

Resources. In fiscal year (FY) 2008, the medical center's medical care budget totaled approximately $132.6 million. FY 2008 staffing was 672 full-time employee equivalents (FTE), including 69 physician and 152 nursing FTE.

Workload. During FY 2007, the medical center treated approximately 23,500 unique patients and provided inpatient care to more than 2,400 patients. The medical center had 60 operating beds and an average daily census of 43. It had no community living center (CLC)[1] beds. Outpatient workload for FY 2007 totaled over 188,000 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:

[1] 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.
- Emergency/Urgent Care (E/UC) Operations.
- EOC.
- Medication Management.
- Pharmacy Operations.
- QM Program.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and quarters 1–3 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 VA Medical Center, White River Junction, Vermont,* Report No.05-01514-96, March 3, 2006). In that report, we identified improvement opportunities in radiology timeliness and EOC. 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 41 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

Robert W. Carey Award

The medical center received the VA Secretary's 2008 Robert W. Carey Circle of Excellence Award. This is the seventh consecutive Carey award for performance excellence that the medical center has received.

Hospitals and Health Networks Award

In July 2008, H&HN released its 10th edition of the "100 Most Wired Hospitals and Health Systems," which highlights the top performers in the use of information technology. For the third year in a row, the medical center received this award in the "small and rural" category. This achievement was featured in a New England nurses magazine.[2]

Improved Hypertension Control

In 2005, only 58 percent of outpatients met the performance measure goal for management of hypertension—blood pressure (BP) less than 140/90 mmHg.[3] Clinical managers initiated a protocol that ensured that clinicians re-checked BPs before the end of the primary care visit when the initial reading was high, took immediate action to intensify therapy if the second BP reading remained elevated, and rescheduled the patient within 2 weeks to assess intensified therapy interventions. As a result, the percent of patients with controlled hypertension has improved to 78 percent.

[2] *ADVANCE for Nurses*, Vol. 8, No. 22, October 20, 2008, p.12.
[3] Millimeters of mercury.

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.

Clinical Reprivileging. Veterans Health Administration (VHA) regulations[4] and Joint Commission (JC) standards[5] 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.[6] At the time of our visit, clinical leaders had completed the credentialing and privileging (C&P) training modules, and plans had been developed for ongoing physician competency monitoring. We reviewed C&P folders and corresponding PI data for 33 providers reprivileged in the past 12 months and found that 29 (88 percent) of 33 had inadequate performance data. Additionally, our review showed that clinical managers granted privileges to some providers for procedures they did not perform.

Peer Review Committee. The PRC met at least quarterly and performed most of the required functions outlined by VHA regulations.[7] However, PRC minutes did not reflect that action items recommended by the committee were

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[5] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, January 2007, MS.4.40.
[6] The process of evaluating professional credentials and clinical competencies of practitioners who hold clinical privileges at the facility.
[7] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

implemented. Additionally, we did not find consistent evidence that the PRC reported quarterly to the CEB.

Patient Safety. VHA's patient safety handbook[8] states that for RCAs to be credible, they must include outcome measures to monitor corrective actions. We found that the medical center had developed processes to ensure that corrective actions recommended by RCAs were implemented. However, the medical center needed to develop processes to ensure that responsible managers monitored the effectiveness of corrective actions on a regular basis. Additionally, managers did not have a plan to implement The JC's national patient safety goal (NPSG) to reduce potential patient harm associated with anticoagulation therapy. Although medical center managers had designated responsibility for the development and implementation of the plan, at the time of our review, this had not yet been accomplished.

Adverse Event Disclosure. VHA regulations[9] require that clinicians disclose adverse events related to clinical care to patients or their personal representatives. We reviewed the medical records of three patients who experienced adverse outcomes and found that in two of the cases, there was no documentation to support that clinicians discussed the events with the patients or their families.

Recommendation 1 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize it during reprivileging.

Recommendation 2 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that clinical managers grant only privileges that are consistent with providers' practices.

Recommendation 3 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that PRC minutes reflect that recommended action items have been implemented and that the PRC report its activity quarterly to the CEB.

[8] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[9] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

Recommendation 4 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that responsible managers monitor corrective actions identified by RCAs and implement The JC's NPSG for anticoagulation therapy.

Recommendation 5 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that clinicians discuss adverse events with patients and document these discussions in the patients' medical records.

The VISN and Acting Medical Center Directors agreed with findings and recommendations. They reported that clinical managers approved and implemented an ongoing performance evaluation policy and that performance data will be reviewed as part of the reprivileging process. Clinical managers conducted a review of clinical privileges and withdrew any privileges that were not consistent with attending physicians' current clinical practice. PRC minutes will indicate that committee recommendations were implemented, and the PRC has begun reporting regularly to the CEB. Additionally, managers improved the methodology for tracking implementation of RCA corrective actions, will fully implement The JC's NPSG for anticoagulation therapy by January 31, 2009, and will monitor adverse event disclosures to ensure that discussions with patients occur and are documented in patients' medical records. The 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 controlled substances (CS) discrepancies at the unit level were adequate. However, we identified two areas that needed

improvement.

Pain Medication Effectiveness. VHA regulations[10] and The JC[11] require that clinicians monitor PRN[12] medications for effectiveness. Additionally, the medical center's policy for Bar Code Medication Administration (BCMA) requires that reassessments of PRN medications occur within 120 minutes after administration.[13] We reviewed 252 administered doses of PRN pain medications. We found that for 202 (80 percent) of the doses, reassessments for effectiveness were either not documented or were not documented within the required timeframe.

Medication Administration. The medical center requires the use of the BCMA system when administering medications.[14] Scanning patients' wristbands prior to administering medication correctly identifies patients and reduces medication errors. We found that staff appropriately scanned patients' wristbands on all units except two. On one unit, the patient was on isolation precautions; on the second unit, the patient had been removed from isolation precautions 2 days prior to our review. Prior to administering the patients' medications, neither of the nurses scanned the wristbands attached to the patients' wrists. Instead, they reached into the patients' rooms from the doorway and scanned surrogate wristbands taped to the walls just inside the doors of each room. Nursing managers reported that this was standard practice for patients on isolation precautions. However, one patient was no longer on isolation precautions, and the practice was inconsistent with the medical center's BCMA policy[15] and the VISN's patient identification policy.[16] Both policies state that scanning patients' wristbands is required, and the medical center's policy cites a process for scanning wristbands of patients on isolation precautions.

Recommendation 6 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses

[10] VHA Directive 2003-021, *Pain Management*, May 2, 2003.
[11] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals,* January 2007, MM.6.10.
[12] PRN is a Latin abbreviation [*L pro re nata*] meaning as needed or as the circumstances require.
[13] White River Junction VA Medical Center Memorandum No. 002-08-32, *Administration of Medications Bar Code Administration (BCMA),* August 1, 2008, p. 5.
[14] Ibid., p. 1.
[15] Ibid., pp. 4, 5.
[16] VA NEHS (New England Healthcare System) Memorandum No. 10N1-33, *Verification of Patient Identification,* June 2004.

document pain reassessments within appropriate timeframes and that compliance be monitored.

Recommendation 7 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses scan all patients' wristbands prior to medication administration and that compliance be monitored.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. They reported that the Associate Director of Nursing and Patient Care Services (ADNPCS) established processes to ensure compliance with PRN pain medication documentation and BCMA policy regarding scanning of all patients' wristbands. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purposes of this review were to evaluate selected aspects of E/UC clinical services, staffing, and staff competencies. We also evaluated whether the physical environment was clean and safe and whether managers maintained equipment appropriately.

The medical center did not have a UC clinic but had 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 patient consults and transfers were appropriate and that staffing was adequate. We found that the area was clean and that managers appropriately maintained equipment. However, we identified one area that needed improvement.

Nurse Competencies. The medical center requires that multiple unit-specific competencies be evaluated annually.[17] We reviewed the competency folders and training summaries of three ED RNs and found that two of the folders did not contain documentation that the RNs met the required annual competencies.

[17] White River Junction VA Medical Center Nursing Service Policy No. 118.41, *Orientation, Evaluation and Assessment of Nursing Competence,* August 4, 2008.

Recommendation 8 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all RNs who work in the ED demonstrate required competencies annually and that compliance is documented.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation. They reported that the ADNPCS established processes to ensure that ED nurses demonstrate proficiency in all required competencies and that this information is documented. The implementation plans are acceptable, and we will follow up on the planned actions until they 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 11 patients discharged from inpatient care and, as part of the ED review, 4 MH patients discharged from the ED. We found documentation deficiencies in 10 (67 percent) of the records reviewed. VHA regulations[18] require that specific information be included in discharge summaries and patient discharge instructions. Seven records had inconsistencies between discharge summaries and patient discharge instructions. Additionally, three records from the ED did not have documentation to support that the patients received discharge instructions at the time of discharge from the ED. The JC requires that clinicians provide written discharge instructions to patients when they are discharged from hospital and ambulatory care facilities.[19]

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

[18] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[19] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, January 2007, PC.15.20; The Joint Commission, *Comprehensive Accreditation Manual for Ambulatory Care*, January 2007, PC.15.20.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation. They reported that the Chief of Staff established processes to ensure that discharge instructions and discharge summaries are consistent. Compliance with this requirement will be incorporated into the clinician evaluation process. 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 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[20] 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 IC issues. In addition, we interviewed CS inspectors and appropriate Pharmacy Service and Police and Security Service managers.

The CS inspection program was organized and well managed. However, we found one condition that posed a potential security and IC risk. The inpatient pharmacy was not equipped with an adequate centralized cooling system to maintain proper temperature control for medication storage without a supplemental cooling system. Consequently, a window air conditioner was installed; however, the unit was improperly sealed. The side curtain assemblies on both sides of the air conditioner had become detached from the unit, leaving openings to the outside. Facility Management Service managers took actions to correct the condition while we were onsite.

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

[20] 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.

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.[21] Some literature suggests that elderly patients and MH patients are among the most vulnerable populations for polypharmacy.[22]

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 10 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that appropriate medication storage temperatures are maintained and that security and IC risks are minimized.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation. They reported that Facilities Management Service removed the window air conditioning unit and cleaned the inpatient pharmacy ventilation system, which improved airflow to the work area. Medication storage temperatures will be monitored during environmental rounds. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

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,

[21] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[22] 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.

Occupational Safety and Health Administration, and JC standards.

We inspected the following areas: (a) the unlocked acute MH unit, (b) two medical/surgical units, (c) the intensive care unit, (d) the gastroenterology clinic, (e) the same day surgery area, and (f) two primary care clinics. The areas we inspected were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their units. Also, we evaluated the IC program's management of data and processes in which the data were used to improve performance and found the program satisfactory. We made no 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 and interviewed nurse managers. We found the staffing methodology to be appropriate. We made no recommendations.

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 SHEP scores for quarter 3 of FY 2006 through quarter 2 of FY 2008. The inpatient and outpatient scores were above target for all quarters. Findings are displayed in the graphs on the next page.

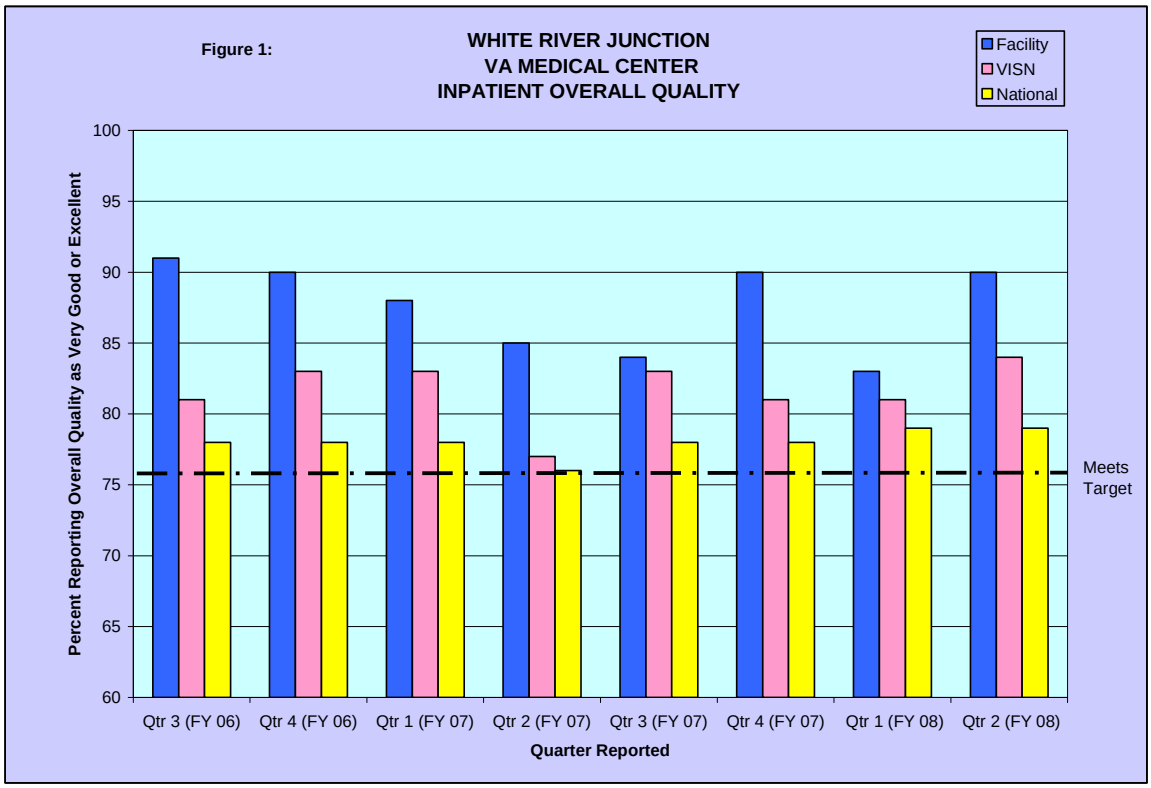
Figure 1:
WHITE RIVER JUNCTION
VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

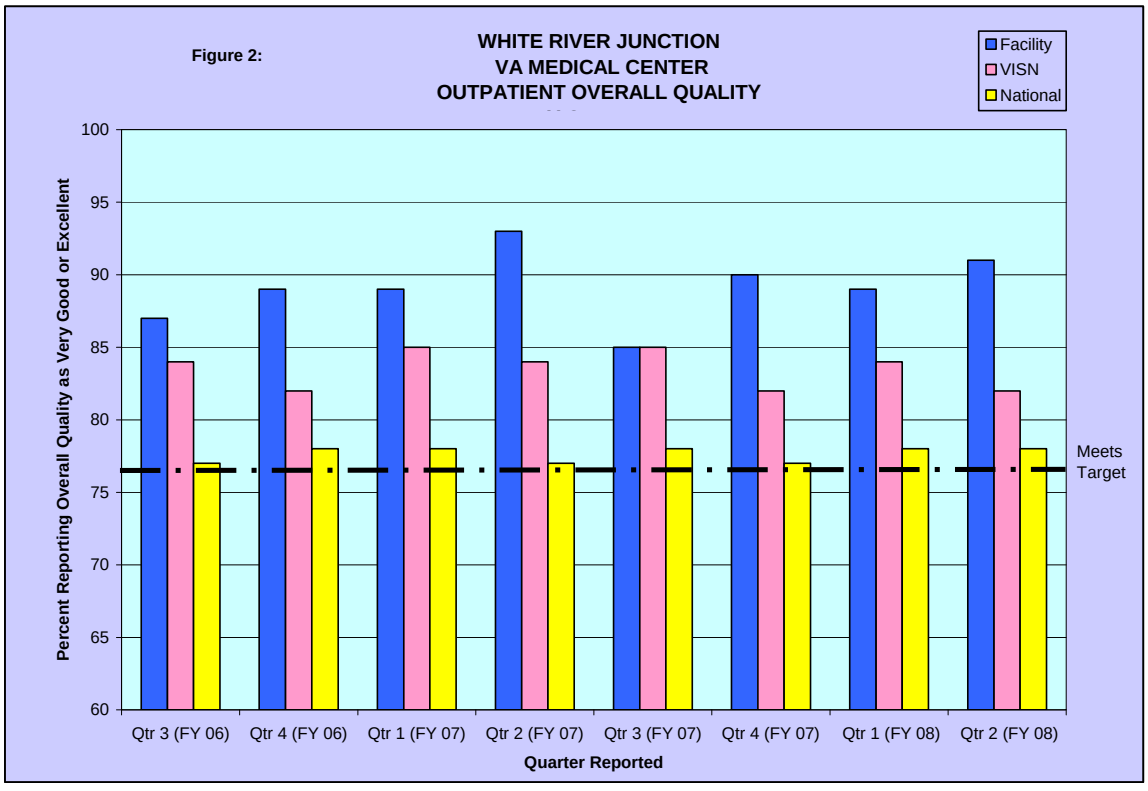
Figure 2:
WHITE RIVER JUNCTION
VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

Even though the medical center exceeded the target scores for all quarters, managers analyzed SHEP data, identified improvement strategies, and monitored the results of the strategies. Survey results and improvement strategies were distributed throughout the organization. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **December 3, 2008**

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

Subject: **Combined Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

We concur with the recommendations and have actions listed below. Please contact VISN 1 Quality Management Officer if anything further is needed.

(original signed by:)

MICHAEL F. MAYO-SMITH, MD, MPH
Network Director

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: **December 2, 2008**

From: Acting Director, White River Junction VA Medical Center (405/00)

Subject: **Combined Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont**

To: Director Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

1. Enclosed are White River Junction's responses to the OIG Combined Assessment Program Report for the October 20–24, 2008, review. We appreciate the input we received from the OIG site visit team and have taken this opportunity to implement timely actions to improve the recommended processes identified in this report.

2. The White River Junction staff is dedicated to providing quality healthcare to our Nation's Veterans. We appreciate the opportunity to implement strategies in response to the recommendations provided. This review process will enable us to enhance the services we deliver at the medical center and to ensure that patient care is delivered in the safest and most effective means possible.

(original signed by:)

Danielle S. Ocker

Acting Director

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 Acting Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize it during reprivileging.

Concur

Two areas require improvement: assurance of current Ongoing Professional Practice Evaluations and use of Focused Professional Practice Evaluations for new staff and enhancement of clinical performance. At a meeting of the Professional Standards Board on 11-20-2008, a proposed policy on ongoing and focused performance evaluation was circulated for review. This policy will be adapted for use and will be implemented at WRJ VAMC no later than 3 December. Current Ongoing Professional Practice Evaluations and appropriate Focused Professional Practice Evaluations will be then required for all Credentialing & Privileging actions taken by the Professional Standards Board.

Status: Completed – 12/3/08

Recommendation 2. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that clinical managers grant only privileges that are consistent with providers' practices.

Concur

This response has two elements: (1) addressing the issue of privileges for procedures done by attending physicians and (2) addressing the issue of privileging documentation which lacks sufficient specificity.

To address element 1, the following actions are described: clinical managers conducted a review of all clinical privileges and withdrew any privileges that were not consistent with attending physicians' current clinical practices. In the future, providers' privileges will be reviewed prior to reprivileging and only those privileges consistent with current practice will be granted.

Status: Completed – 12/3/08

To address element 2, Chief Of Staff has solicited forms from two Complexity Level 2 facilities that have successfully been reviewed by OIG and SOARS. These more-specific privileging systems will be presented to the Professional Standards Board. A new system will be adopted for use by the Professional Standards Board not later than 12/3/2008.

Status: Completed – 12/3/08

Recommendation 3. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that Peer Review Committee minutes reflect that recommended action items have been implemented and that the Peer Review Committee report its activity quarterly to the Clinical Executive Board.

Concur

This practice was established at the last Peer Review Committee meeting.

Status: Completed -11/26/08

Recommendation 4. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that responsible managers monitor corrective actions identified by RCAs and implement The JC's anticoagulation therapy national patient safety goal.

Concur

1) A plan to monitor the corrective actions of all open Root Cause Analyses' (RCA) actions is currently in place. The WRJ Patient Safety Manager has updated the tool to monitor corrective actions to include time-line of actions implemented, an effectiveness plan, and a departmental point of contact for future coordination.

Status: Completed – 10/23/08

Completion of RCA action items continues, working from most current, back, by the Patient Safety Manager with assistance from the onsite Patient Safety fellows. All FY 2008 RCA corrective actions will be completed by 1/31/09.

Status: Target completion date – 1/31/09

2) A defined anticoagulation therapy program currently exists at the WRJ VAMC. Program management is currently in the process of updating its center directive to better reflect the Joint Commission National Patient Safety Goals, in addition to implementing a more inclusive tool for

administering anticoagulation training to prescribers and staff to be in full compliance with the national patient safety goal.

Status: Target completion date 1/1/09

Anticoagulation safety will be monitored via adverse drug event reporting and medical error/patient safety incident reporting, as well as a medication use evaluation monitor at least annually.

Recommendation 5. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that clinicians discuss adverse events with patients and document these discussions in the patients' medical records.

Concur

1) The Risk Manager and Chief of Staff presented a discussion of adverse event disclosure to the Clinical Executive Board in October 2008.

Status: Completed 10/29/08

2) The Risk Manager will present an "Adverse Event Talking Points" document to all individual clinical services by 12/31/08. This document, abstracted from our more lengthy facility center memo, briefly gives specific instructions for the appropriate and timely use and documentation of adverse event disclosure. Monitoring of ongoing effectiveness and tracking of adverse event disclosures will be done at the time of each adverse event report submission.

Status: Completed – 10/29/08

Recommendation 6. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses document pain reassessments within appropriate timeframes and that compliance be monitored.

Concur

The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to Nursing Leadership and by an electronic ADNPCS Clinical Bulletin - Medication Management, to all RNs and LPNs. As of Nov. 10, 2008, on a weekly basis PRN effectiveness is monitored and outliers identified and responsible parties are individually reeducated in the process of documentation requirements. The effectiveness of this action plan will be monitored, tracked and trended by the BCMA Committee and reported to the ADNPCS on a monthly basis. The ADNPCS Clinical Bulletin included notification to nursing staff of the

inclusion in annual performance plans of a practice performance requirement that 90% of all PRN medications administered will have their effectiveness documented in BCMA/electronic medical record.

Status: Completed – 11/10/2008

Recommendation 7. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses scan all patients' wristbands prior to medication administration and that compliance be monitored.

Concur

The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to Nursing Leadership and by an electronic ADNPCS Clinical Bulletin-Medication Management, to all RNs and LPNs. As of 11/17/2008, nurse managers have instructed all staff that administers medications that wristbands will be scanned according to the Bar Code Medication Administration policy. Compliance to direct scanning of the patient's wristband will be monitored by unit nurse managers with outliers being identified and responsible parties individually reeducated in the process.

Status: Completed – 11/17/2008

Recommendation 8. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all RNs who work in the ED demonstrate required competencies annually and compliance is documented.

Concur

The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation. Nursing Services current competency assessment program is unit based with specific competencies and competency checklist for the Emergency Department as well as all other nursing clinical areas and is completed annually at the time of annual proficiency review for Title 38 staff and the Title 5 Performance Rating period for Title 5/Title 38 Hybrids. As of 11/17/08, enforcement of the current nursing competency process per nursing service policy was communicated to all nurse leaders. Completion of the competency checklist was also added to Nursing's Proficiency Tracking database with compliance being monitored by the ADNPCS.

Status: Completed – 11/17/08

Given Nursing's Competency Assessment Program was last updated in 2002, a "Plan-Do-Check-Act" improvement project of the nursing competency process will be conducted with a cycle of refinement.

Status: Target completion date - 3/1/09

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

Concur

Chief of Staff will direct that Service Chiefs provide guidance to inpatient attendings regarding this responsibility, and that compliance with this requirement be tracked as part of the evaluation process of ward attending staff.

Status: Completed -11/28/08

Recommendation 10. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that appropriate medication storage temperatures are maintained and that security and IC risks are minimized.

Concur

1) A temporary barrier was inserted into the pharmacy window where a portable air conditioner was located. This temporary measure was assessed for safety/security by the Chief of Facilities Management Service and the Acting Chief of Police on 11/18/08.

2) It was determined that this measure may not completely eliminate the security risks associated with the pharmacy. This assessment resulted in the removal of the portable window air conditioner on 11/18/08 by Facilities Management.

3) The ventilation system in the pharmacy was assessed and cleaned during the first week of November 2008. This has resulted in increased air flow to that work area. This action item has been corrected. Ongoing assessment of medication storage temperatures will be conducted during environmental rounds.

Status: Completed – 11/18/08

OIG Contact and Staff Acknowledgments

Contact	Katherine Owens, MSN, Director Bedford Office of Healthcare Inspections (603) 222-5871
Contributors	Annette Acosta, MN, Team Leader Nancy Albaladejo, MSN Kathy Gudgell, BSN Jeanne Martin, Pharm.D. Glen Pickens, BSN Sean Smith, Office of Investigations

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