Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03275-71

Combined Assessment Program Review of the Lebanon VA Medical Center Lebanon, Pennsylvania

February 19, 2009

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 December 15–19, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Lebanon VA Medical Center (the medical center), Lebanon, PA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 106 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Methicillin-resistant *Staphylococcus aureus* (MRSA) prevention program.
- Safe patient handling.

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

- Ensure that discharge instructions are consistent with discharge summaries.
- Verify appropriate out-of-operating room airway management credentials prior to granting provider privileges.
- Ensure that the Multidisciplinary Safety Inspection Team (MSIT) has all required disciplines represented and that the team members receive the required annual environmental hazards training.
- Require annual fire safety inspections of all community based outpatient clinics (CBOCs).
- Document pain reassessments within the appropriate timeframe and monitor compliance.

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

- Patient Satisfaction.
- Pharmacy Operations.

- QM Program.
- Staffing.

This report was prepared under the direction of Randall Snow, JD, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 13–17, 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 Lebanon, PA, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six CBOCs in York, Camp Hill, Pottsville, Frackville, Reading, and Lancaster, PA. The medical center is part of VISN 4 and serves a veteran population of approximately 210,000 in a primary service area that includes 13 counties in Pennsylvania.

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

Affiliations and Research. The medical center is affiliated with the Penn State College of Medicine and supports 60 medical student and 25 medical resident positions. In fiscal year (FY) 2008, approximately 220 associated health trainee students from 76 different schools rotated through the medical center. The medical center's FY 2008 research program had 11 projects and a budget of $155,000. Major areas of research included acute renal failure, prostate cancer, diabetes, and patient safety.

Resources. In FY 2008 the medical care budget was approximately $199.5 million. FY 2008 staffing was 1,220.2 full-time employee equivalents (FTE), including 58.5 physician and 334.9 nursing FTE.

Workload. In FY 2008, the medical center treated 42,176 unique patients and provided 31,355 inpatient days in the hospital and 30,637 inpatient days in the community living center (CLC).[1] The inpatient care workload totaled 3,069 discharges, and the average daily census, including CLC patients, was 169.8. The outpatient workload totaled 397,161 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 Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- Pharmacy Operations.
- QM Program.
- 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 select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Lebanon, Pennsylvania,* Report No. 05-02502-99, March 7, 2006). 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 also presented fraud and integrity awareness briefings for 106 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 Strengths

Methicillin-Resistant *Staphylococcus Aureus* Prevention Program

MRSA is a strain of *Staphylococcus aureus*[2] that is resistant to a large group of antibiotics called the beta-lactams, which include the penicillins and the cephalosporins. Due to the increase in MSRA-related deaths, the medical center developed and implemented its own hand hygiene prevention program, which produced excellent results. The medical center exported the program to school districts in the surrounding community to help ensure a safe and germ-free environment for students. The Pennsylvania Department of Health has asked the VA employees who developed the program to assist in promoting community awareness throughout the state.

Safe Patient Handling

In an effort to prevent musculoskeletal injuries to staff and eliminate injuries associated with patient handling and movement, the medical center installed ceiling lifts in patient rooms, the intensive care unit, the emergency department (ED), and the physical and occupational therapy clinics. After installation of the lifts, the medical center recorded a 40 percent reduction in staff injuries from FY 2007 to FY 2008. Medical center staff are currently participating in the VA Safe Patient Handling Initiative.

Results

Review Activities With Recommendations

Coordination of Care

The purpose of this review was to evaluate whether selected aspects of care, such as consultations, intra-facility transfers, and discharges, were coordinated appropriately over the continuum of care. Timely responses to consults, effective

[2] *Staphylococcus aureus* is the most common cause of staph infections. It is frequently found in a person's nose and skin and can cause a range of illnesses from minor skin infections to life-threatening diseases. It is one of the most common causes of hospital-acquired infections.

management of patient transfers, and appropriate discharge instructions are essential to optimal patient outcomes. We found that providers managed patient consults and intra-facility transfers appropriately. However, we identified the following area that needed improvement.

Patient Discharges. Veterans Health Administration (VHA) regulations[3] require that specific information be included in both discharge summaries and patient discharge instructions. We reviewed medical record documentation for nine patients discharged from inpatient care. Three of the records had inconsistencies in medications listed in the discharge summary and those listed in the discharge instructions.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge instructions are consistent with discharge summaries.

The VISN and Medical Center Directors concurred with the finding and recommendation. They reported that prior to authenticating discharge instructions, the provider will be required to electronically copy the medication list from the discharge instruction sheet and paste it in the discharge summary. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in VHA EDs, such as clinical services, consults, inter-facility transfers, staffing, and staff competencies. We also determined whether the physical environment was clean and safe and whether equipment was appropriately maintained.

We interviewed physicians, the ED program manager, and others from the Critical Care Service Line. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging folders. We reviewed the medical records of patients who were transferred to other medical facilities or admitted to inpatient units within the medical center.

Our review showed that clinical services, consults, and staffing were appropriate. Emergency services provided are

[3] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

within the medical center's patient care capabilities. In addition, we found appropriate policies for managing patients whose care may exceed the medical center's capability.

We conducted an EOC tour and found that the ED was clean and safe. Also, the ED has a mental health observation room that enhanced patient safety. The following area needed improvement.

Clinical Privileging. We reviewed 16 credentialing and privileging folders of physicians employed in the ED. We found that four had been granted intubation privileges without documented evidence of out-of-operating room airway management training or other performance monitoring data, such as the number of intubations performed over a specific time period with applicable complication rates. This type of documentation is required by VHA.[4]

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to perform procedures only after verification of appropriate training.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center modified the competency validation process by developing an educational syllabus, providing physician training, and scheduling skills demonstrations with the Director of Anesthesia. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the infection control (IC) program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections,

[4] VHA Directive 2005-031, *Out-Of-Operating Room Airway Management,* August 8, 2005.

and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff. Additionally, we reviewed the locked acute inpatient behavioral health unit to determine if the MSIT identified and mitigated environmental hazards that pose a threat to patients and to ensure that the team and staff received specialized training.

We inspected the following areas: (a) the intensive care unit, (b) the medical surgical unit, (c) the locked acute inpatient behavioral health unit, (c) the CLC, (d) the operating room, and (e) the outpatient clinics. The facility was very clean and well maintained. However, we identified the following conditions that required attention.

Locked Acute Inpatient Behavioral Health Unit. The MSIT has implemented changes to protect the patient population. However, the team does not have all the required disciplines represented, and the team members have not received the required annual environmental hazards training.[5]

Safety Inspection. The Pottsville CBOC is a contacted facility that is shared with the Wilkes-Barre VA Medical Center (Wilkes-Barre). Wilkes-Barre had been responsible for oversight of all Federal, state, and local fire safety codes until July 2008 when this medical center assumed responsibility for monitoring and conducting annual fire drills. We found that the medical center had not conducted its own fire safety inspection of the CBOC.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the MSIT includes representation from all required disciplines and that the team members receive the required annual environmental hazards training.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center appointed an additional member to the MSIT, which now includes all VHA required inspection team participants. Also, the medical center provided initial training for all team members, and annual training has been scheduled. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[5] VHA Center for Engineering and Occupational Safety and Health, Mental Health Environment of Care Memorandum, August 27, 2007.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires annual fire safety inspections of all CBOCs.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center has included the Pottsville CBOC in the annual fire safety inspection schedule. The implementation plan is acceptable, and we will follow up on the planned action until it is 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. We identified one area that needed improvement.

Pain Medication Effectiveness. VHA regulations[6] and The Joint Commission require that clinicians monitor PRN (as needed) pain medications for effectiveness. Additionally, the medical center's policy for pain assessment requires that reassessments of PRN medications occur within 1 hour after administration. We reviewed 25 administered doses of PRN pain medications. We found that for 18 (72 percent) of the doses, reassessments for effectiveness were not documented within the required timeframe.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses document pain reassessments within the required timeframe and that compliance is monitored.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center added a

[6] VHA Directive 2003-021, *Pain Management,* May 2, 2003.

field to the Bar Code Medication Administration system to allow for documentation of the actual time of patient reassessment in the electronic medical record. Training on the use of this field has been provided to nursing staff. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Patient Satisfaction

The purpose of this review was to assess the extent that VHA medical facilities used quarterly or semi-annual Survey of Healthcare Experiences of Patients (SHEP) results to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

We reviewed SHEP results for quarters 3 and 4 of FY 2006, all quarters of FY 2007, and quarters 1 and 2 of FY 2008. Figures 1 and 2 on the next page show the medical center's patient satisfaction performance measure results for inpatients and outpatients, respectively.

Figure 1:

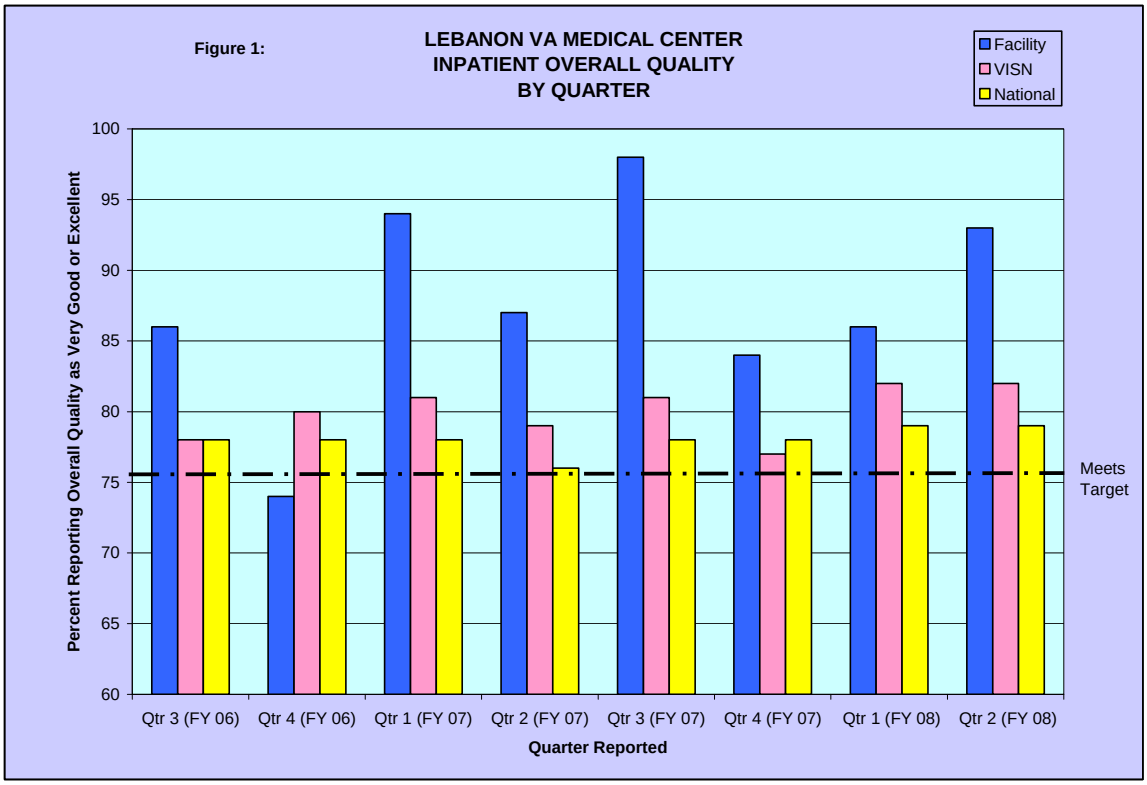
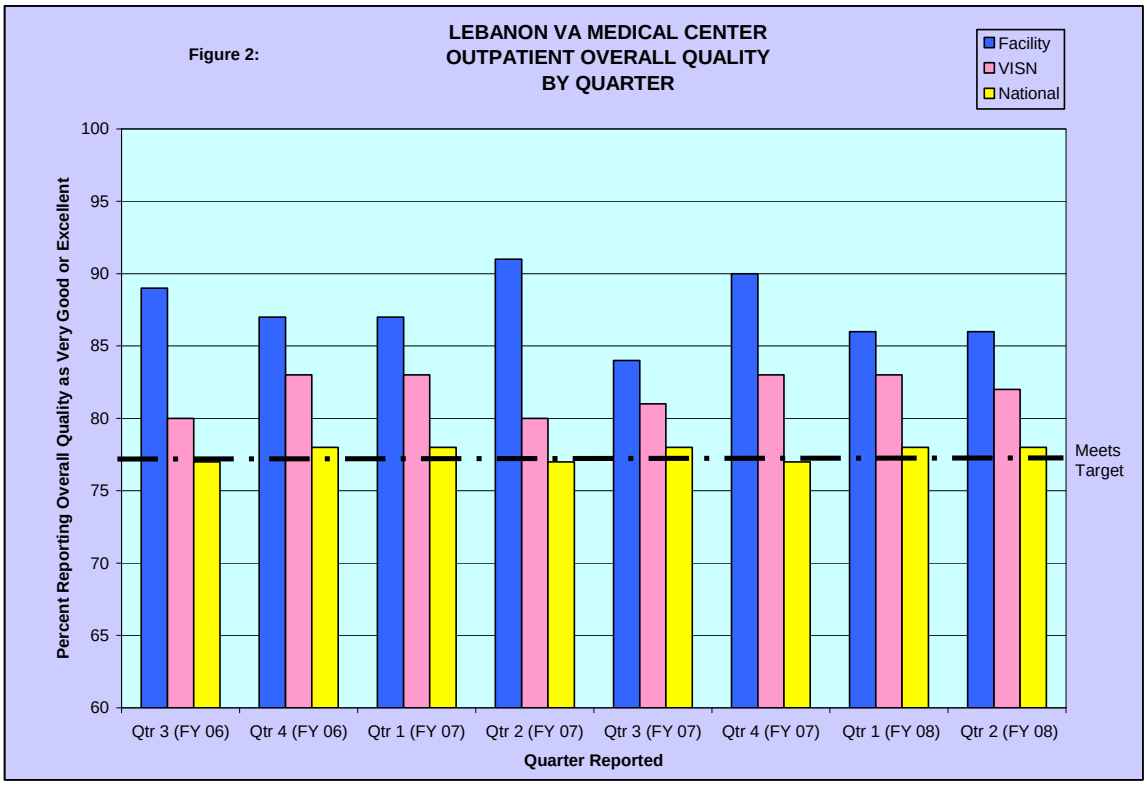


Figure 2:



The medical center's inpatient scores met or exceeded the target in all but 1 quarter. Outpatient scores met or exceeded the target in all 8 quarters. Nationally, the medical center ranked in the top 10 in 7 of the 11 performance measures. It ranked first in preferences; third in access, emotional support, specialist care, and visit coordination; and fourth in education and information. Also, the medical center ranked first in the Nation for inpatient courtesy scores.

We made no recommendations.

Pharmacy Operations

The purpose of this review was to evaluate whether the medical center had adequate controls to ensure the security and proper management of CS and the pharmacy's internal physical environment. We also evaluated whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of the pharmacy and CS. CS inspections were conducted according to VHA regulations, and training records showed that the CS coordinator and inspectors received appropriate training to execute their duties. Managers reported all CS diversions or suspected diversions to the OIG. The pharmacy's internal EOC was secure, clean, and well maintained.

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.[7] Some literature suggests that

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

elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[8]

We found that managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

We made no recommendations.

Quality Management Program

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

The medical center's QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. In addition, clinical managers had developed a provider performance evaluation plan.

We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the medical center had developed staffing guidelines for the nursing staff, and we found them to be adequate.

The medical center uses nursing hours per patient day (NHPPD) as the primary staffing methodology. We reviewed staffing for six inpatient units for a total of 72 shifts. We found that nurse staffing requirements were met 89 percent of the time in all areas reviewed and that specific actions had

[8] 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.

been taken to ensure safe patient care, including the use of supplemental staffing and one-to-one staffing, when needed.

Overall, we found that the medical center had adequate nursing staff. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 21, 2009

From: VISN Director

Subject: **Combined Assessment Program Review of the Lebanon VA Medical Center, Lebanon, Pennsylvania**

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

Director, Management Review Service (10B5)

1. I have reviewed the response to the OIG recommendations made by the Lebanon VA Medical Center and concur with all actions. We appreciate the opportunity for review of our processes at the medical center.

(original signed by:)

MICHAEL E. MORELAND, FACHE

Network Director

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 20, 2009

From: Lebanon VA Medical Center Director

Subject: **Combined Assessment Program Review of the Lebanon VA Medical Center, Lebanon, Pennsylvania**

To: Office of Inspector General

The Lebanon VA Medical Center appreciated the opportunity to have an external inspection team from the Office of the Inspector General visit our facility in December 2008. We are pleased with their validation of our organization's strengths and acknowledgement of the impact our hard working staff had in the pursuit of safe, high quality veteran care.

After a careful review of this OIG Combined Assessment Program report, the Lebanon VA Medical Center implemented improvements to the recommendations with all completed except for one.

We want to thank this dedicated team of inspectors who acknowledged our best practices, informed us of other organization best practices, and thoroughly evaluated Lebanon VAMC's implementation of VHA directives on behalf of this nation's veterans.

Sincerely,

(original signed by:)

Robert W. Callahan, Jr.

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 Medical Center Director requires that discharge instructions are consistent with discharge summaries.

Concur

To address this issue, LVAMC has clearly defined the inpatient discharge medication list documentation as:

- When documenting the discharge summary, providers will pull for inclusion the medication list from the discharge instruction sheet.
- When dictating the discharge summary, transcription will transcribe the note and the provider will pull the medication list from the discharge instruction sheet for inclusion when they review and authenticate it.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that providers are privileged to perform procedures only after verification of appropriate training.

Concur

LVAMC acknowledges that Emergency Department physicians (18) were deemed privileged in out-of-operating room airway management using the guidelines from the American College of Emergency Physicians. As a follow up to this inspection, LVAMC modified the competency process to ensure compliance with the VHA Directive 2005-031 – Out-of-Operating Room Airway Management Competency Assessment by:

- developing an educational syllabus for physician training which contains all required elements.
- providing physician training using the educational syllabus and interaction, where indicated, to all Emergency Department physicians.

- developing a schedule for demonstration of skills in collaboration with the Director of Anesthesia.

- conducting skills demonstration to validate competency. Lebanon is in the process of having all Emergency Department physicians demonstrate the procedural skill in accordance with requirement elements in this VHA Directive with a completion date of February 16, 2009.

- implemented a communication methodology between the credentialing coordinator and Chief Physician of the Emergency Department to ensure ongoing coordination and timely competency re-assessment at the time of re-privileging.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the MSIT includes representation from all required disciplines and that the team members receive the required annual environmental hazards training.

Concur

The MSIT team received initial training relative to The Mental Health Environment of Care Checklist for Locked Mental Health Units (MHEOCC) when first made available in July 2008 (specifically July 21, 2008). The next annual training for the multidisciplinary safety inspection team (MSIT), is scheduled for July 2009.

Please note that no environment of care findings were reported when the OIG visited the inpatient behavior health unit. Further, in addition to the annual inspection requirement, LVAMC completed 3 separate MSIT environmental inspections during the calendar year utilizing the Mental Health Environment of Care Checklist to ensure safety.

A non-behavioral health nurse manager has been added to the MSIT, completing the complement to now include all VHA required team participants. This new member completed initial training in December 2008 and anticipates annual re-training with other MSIT members as specified above.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires annual fire safety inspections of all CBOCs.

Concur

Lebanon began transitioning oversight of the contract community based outpatient clinic in July 2008 and full oversight in October 2008. The

annual safety inspection has been scheduled and will be completed by January 27, 2009.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses document pain reassessments within the require timeframe and that compliance is monitored.

Concur

Local policy required the reassessment of pain medication within 30 minutes of parenteral administration and within 1 hour of oral administration. Documentation of the reassessment is required within 4 hours of the actual reassessment. The OIG Inspectors reported believing reassessment was within appropriate timeframes. However, auto date stamp for BCMA documentation appears as if reassessment occurred outside of the required timeframe.

Action taken: Medication reassessment in BCMA includes a field for allowing the documentation of the actual time the reassessment occurs despite when the documentation entry is completed. Appropriate medical center staff has been educated to the utilization of this field, and the BCMA educational curriculum for new employees has been updated to include this level of documentation.

OIG Contact and Staff Acknowledgments

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