Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center Milwaukee, Wisconsin

Report No. 07-00060-121 **April 27, 2007**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are 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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of December 4–8, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Clement J. Zablocki VA Medical Center (the medical center), Milwaukee, Wisconsin. 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 200 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of Review

The CAP review covered nine areas. The medical center complied with selected standards in the following six areas:

- Survey of Healthcare Experiences of Patients (SHEP).
- Diabetes and Atypical Antipsychotic Medications.
- Laboratory Security.
- Management of Violent Patients.
- QM Program.
- VA Community Based Outpatient Clinics (CBOCs).

We identified the following organizational strengths:

- Seamless Transition Program.
- Communication Strategies.

We made recommendations in three of the nine areas reviewed. For these areas, the medical center needed to:

- Correct environmental deficiencies.
- Improve selected aspects of the Contract Community Nursing Home (CNH) Program.
- Improve the informed consent process and ensure all clinical providers receive cardiopulmonary resuscitation (CPR) education.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago 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 15–21, 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

Medical Center Profile

Organization. The Clement J. Zablocki VA Medical Center is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs located in Cleveland, Union Grove, Appleton, and Green Bay, Wisconsin. The medical center is part of VISN 12 and serves a veteran population of about 234,953 in a primary service area that includes 15 counties in the eastern part of Wisconsin.

Programs. The medical center provides spinal cord injury care and medical, surgical, mental health, geriatric, and rehabilitation services. There are 170 hospital beds and 113 nursing home beds. The medical center operates several regional referral and treatment programs, including open heart surgery, and a wide array of mental health programs, including programs at the domiciliary level of care. The medical center also has sharing agreements that are contracted through the VISN's VA Great Lakes Acquisition Center.

Affiliations and Research. The medical center is affiliated with the Medical College of Wisconsin and supports 142 medical resident positions in 31 training programs. Other affiliations provide for training in many health care fields. In fiscal year (FY) 2006, the medical center research program had 365 projects and a VA budget of $3.3 million. Important areas of research include kidney and gall bladder diseases and oncology.

Resources. The FY 2006 medical care general purpose budget was $256.9 million. FY 2006 staffing totaled 1,931 full-time employee equivalents (FTE), including 135 physician and 668 nurse FTE.

Workload. In FY 2006, the medical center treated 53,284 unique patients. The medical center provided 50,359 inpatient days of care in the hospital and 29,638 inpatient days of care in the Nursing Home Care Unit. The domiciliary provided 93,406 bed days of care. The hospital inpatient care workload totaled 6,583 discharges, and the average daily census, including nursing home patients, was 475. The outpatient workload was 545,005 visits.

Objectives and Scope of the Combined Assessment Program Review

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

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

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

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

Cardiac Catheterization Laboratory Standards	Management of Violent Patients
Diabetes and Atypical Antipsychotic Medications	QM Program
Environment of Care	SHEP
Laboratory Security	CBOCs
	CNH Program

The review covered medical center operations for FY 2006 and FY 2007 through November 30, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

We followed up on one recommendation (Laboratory Security) and two suggestions (Environment of Care and Management of Violent Patients) from the previous CAP review (*Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin,* Report No. 03-00445-173, August 29, 2003*).* Medical center managers were in compliance with the previous recommendation for Laboratory Security and our suggestion for Management of Violent Patients, but they needed to improve in the Environment of Care.

In this report we make recommendations for improvement that pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section entitled "Other Review Topics" have no reportable conditions.

Results of Review

Organizational Strengths

Seamless Transition Program – Ensures Access to Care for Operation Enduring Freedom/Operation Iraqi Freedom Veterans

The medical center reaches out to returning combat veterans and their families by facilitating a smooth transition from the unique demands of serving on active duty to the daily activities of civilian life. During the last 3 FYs, the number of veterans receiving care in the Seamless Transition Program has increased (see table).

Milwaukee VA's Seamless Transition Report Summary Operation Enduring Freedom/Operation Iraqi Freedom Veterans			
	FY 2004	FY 2005	FY 2006
Active Duty	30	23	31
Separated or In Transition	406	809	1,656
Inpatient	25	41	99
Outpatient	416	831	1,662

Please note that the chart above tallies patient encounters, not "unique" patients and consequently, the numbers do not total. The medical center implemented the following initiatives:

- A Seamless Transition Advisory Board was established to identify strategies for continued access to care and to improve care.
- Social work and case management services were enhanced.
- An outreach team was developed to provide education and support.
- Brochures detailing all services available at the medical center were developed.
- Provisions to offer comprehensive post-deployment mental health services were completed.

Communication Strategies – Patient Satisfaction Strengthened

In response to a VISN-identified focus on improving emotional support to patients, the medical center's Customer Service Team developed two approaches to improve communication of important information to patients and family members.

- White dry erase boards were installed in patients' rooms. These white boards are used daily by staff to identify the names of patients' physicians and nurses and to list daily appointments and activities. Currently, 80 patient care rooms are equipped with the white boards. Plans have been approved to purchase additional white boards for use in all patient rooms, except those on the locked mental health unit. The Customer Service Team conducted rounds and interviewed patients and their family members to assess responses to the use of the white boards. All expressed appreciation for staff efforts to keep them informed.

- Blue discharge folders that contain basic information about the medical center, appropriate patient education materials specific to a patient's condition, clinician provider contact information, and discharge information are provided to each patient upon admission as part of the discharge process. During the period of September 1–14, 2006, staff interviewed 116 of 333 discharged patients from three units regarding their blue discharge folders. Of those contacted, 104 (90 percent) found the folder informative, useful, and helpful.

Opportunities for Improvement

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Conditions Needing Improvement. VA policy requires that the medical center be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected four patient care units and found that they were clean and effectively maintained. Managers were responsive to concerns identified during the CAP review. We identified the following deficiencies that required management attention.

Infection Control Concerns. Refrigerator and freezer temperatures must be monitored on a daily basis to ensure the integrity of medications or patient nourishments stored within them. We identified selected dates during November and December when temperatures were not recorded on the log sheets.

Employees need to inspect patient care items regularly for damaged surfaces and either request repair or remove them from service when damage is noted. We observed a raised, cushioned commode seat that was torn and pillows on patient beds that were cracked. Additionally, raised, cushioned commode seats have seams that are problematic to clean. We recommended that managers either conduct training with housekeeping staff to ensure that commode seats are thoroughly cleaned or that they consider an alternative design with smooth surfaces.

Emergency call system cords must be accessible and easily cleaned, as they are often located in shower areas and near commodes and sinks. The medical center generally used plastic cords; however, we observed rope-style emergency call system cords in patient showers and near one sink area. Rope-style cords are porous and cannot be easily cleaned. Additionally, we identified some cords that could not be accessed from floor level and others that were too long with the excess resting on the floor.

During the previous CAP review inspection, dirty or worn gaskets were observed on some refrigerators and freezers. During the patient care unit inspections conducted for this CAP review, we identified two medication refrigerators with dirty or worn gaskets.

Patient Privacy Concerns. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that patient health information be protected at all times from unauthorized access. We observed a document at a computer workstation in a hallway, documents that were in a plastic holder in a hallway outside a staff office, and clipboards hanging from handrails outside patient rooms. All of these documents contained sensitive patient information that could be accessed by unauthorized individuals.

Safety Concerns. Unlocked dirty and clean supply utility rooms on patient care units could be accessed by unauthorized individuals. The utility rooms contained sharp items,

cleaning products, and other fluids that are drinkable that may cause injury. The clean supply utility rooms were vulnerable to tampering or theft.

Patient medications must be secured at all times. We observed a medication cart in the hallway outside a patient room that was unlocked. The nurse was in the patient's room, and the automatic-locking feature on the cart had malfunctioned.

Cleaning products must be secured in patient care areas. A floor buffer with a bottle of cleaning product hanging from the handle was observed in a patient dining room. This item should have been appropriately stored and the cleaning product secured.

A missing light cover over a sink in the locked mental health unit allowed access to the fluorescent bulbs, which could be removed and cause injury.

A ceiling panel in the restroom of a seclusion room in the locked mental health unit was not flush to the ceiling, was accessible by standing on the commode, and could potentially be used as a ligature point.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that the identified infection control, patient privacy, and safety concerns are corrected.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will continue environmental rounds and tracer activities and will correct all deficiencies identified during the review. Compliance will be monitored through ongoing inspections of patient care areas. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contract Community Nursing Home Program – Selected Program Aspects Required Improvement

Conditions Needing Improvement. Veterans Health Administration (VHA) Handbook 1143.2[1] provides guidelines for the VA CNH Program, including oversight and monitoring of patients who are placed in CNHs by VA facilities. We visited VA patients in two CNH facilities and found they were receiving adequate care. Additionally, we interviewed administrators and nurse managers at both facilities, and they reported having a positive relationship and patient-centered communications with VA staff. We identified three CNH program aspects that required management attention.

Oversight Committee. VA facilities are required to have a local oversight committee that monitors CNH program activities. This committee should meet quarterly, report to a chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent), and include multidisciplinary management-level representatives from social

[1] VHA Handbook 1143.2 is *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

work, nursing, QM, acquisition, and the medical staff. The medical center did not have a CNH Oversight Committee. Annual CNH reports were forwarded to the Medical Executive Committee; however, this committee did not include the required membership.

Annual Inspections. Inspection activities must reflect that the safety manager is involved in the annual inspection process for each CNH. We reviewed documentation of annual inspections conducted by the medical center's CNH Inspection Team for five CNH facilities during the past 5 years. We found four instances in which there were 2-year lapses between safety inspections.

Patient Monitoring. We reviewed the medical records of 10 VA patients who were placed in CNH facilities. Nine of the patients did not receive VA staff visits and/or monitoring, as required by VHA policy, specifically, there was a lack of documented visits or monitoring by a registered nurse. Managers needed to ensure that a nurse is consistently involved in follow-up care for the CNH patients who are in contract facilities.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that CNH program activities are monitored by a local CNH oversight committee with the required representation, annual CNH inspection activities are completed by each member of the CNH Inspection Team, and VA patients in CNH facilities receive VA staff visits and monitoring per policy.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will establish a local Community Based Programs Oversight Committee. This committee will monitor annual CNH inspections and follow-up visits of VA-placed patients. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Cardiac Catheterization Laboratory Standards – Informed Consent Process Needed To Be Improved and Clinical Providers Needed Current Cardiopulmonary Resuscitation Education

Conditions Needing Improvement. The purpose of the review was to determine if the medical center's cardiac catheterization laboratory practices were consistent with the American College of Cardiology/Society for Cardiac Angiography and Interventions *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards* published in 2001 and with VHA policy. These standards define requirements for clinical providers' procedure volumes, laboratory procedure volumes, cardiac surgery resources, QM, the informed consent process, and CPR training.

We reviewed a sample of 10 randomly selected patients' records to determine the quality of the informed consent process, outcomes of the cardiac catheterization procedures, and

if applicable, availability of surgery. None of the 10 patients had complications or required surgery. We identified two areas that required management attention.

Informed Consent. VHA policy requires that all practitioners who participate in cardiac catheterization procedures must be identified on the informed consent. Two informed consents listed names of attending physicians who did not perform the procedures. In addition, two informed consents only listed the counseling practitioner's initials.

Cardiopulmonary Resuscitation. VHA policy requires that all clinically active staff have current CPR education. There was no documentation of CPR education for two of four cardiac catheterization laboratory clinical providers during FY 2005. One provider was no longer employed by the medical center, and managers informed us that the remaining provider would be immediately scheduled for training. Contrary to VHA policy, the medical center's CPR policy does not require clinically active staff to maintain current training.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical providers complete informed consents for cardiac catheterization procedures that are consistent with VHA policy, all clinically active staff complete CPR education, and management officials review and revise the current CPR policy to clearly reflect VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will provide education to cardiology staff and residents on the informed consent process. All credentialed and privileged staff will complete CPR education by January 15, 2007, and facility policy will be revised to reflect CPR expectations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Other Areas Reviewed

Survey of Healthcare Experiences of Patients – Action Plan Was Implemented

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying patients using a standardized instrument modeled from Picker Institute, a non-profit health care surveying group. Performance Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006 states that in FY 2006, the percent of patients reporting overall satisfaction as Very Good or Excellent will meet or exceed targets for the performance period October 2005–June 2006 as shown in the table below:

	Meets Target	Exceeds Target
Ambulatory Care	77%	80%
Inpatients (Discharged 10/2004–6/2005)	76%	79%

The following graphs show the medical center's SHEP results for inpatients and outpatients:

Inpatient SHEP Results										
	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03	**
VISN	81.00	77.10	89.30	66.90	64.40	75.80	85.10	73.20	70.10	**
Medical Center	81.80	78.00	92.30	70.10	67.70	77.40	86.70	77.70	74.30	**

Outpatient SHEP Results											
	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.9	77	94.6	72	83	75.1	81.1	64.4	81.3	80.5	84.1
VISN	81.8	72.3	94.2	70.8	82	73.2	83.1	65.8	81.2	79.1	85
Outpatient Clinics	85.7	76.3	95.8	73.3	82.9	73.8	89.3	77.2	83.9	81.2	83.6

Legend: ** Less than 30 respondents

The medical center's inpatient SHEP scores were above the target score as defined by Performance Measure 21 in six of the nine dimensions reported and were significantly better than the national averages for five of those dimensions. Outpatient SHEP scores surpassed the target scores in 8 of 11 dimensions of care. SHEP results were discussed monthly at the Customer Service Council meetings. SHEP results were communicated to employees through town hall meetings, service-level meetings, and published minutes from the Customer Service Council meetings. Committee members regularly conducted customer service rounds on inpatient units to evaluate the consistency of use of white boards at the bedside and the effectiveness of communication following the placement of those white boards. To further enhance emotional support and patient education, patients receive their discharge information and instructions in a blue folder. Follow-up telephone calls to discharged patients regarding the helpfulness of these blue folders are now made 48 hours following discharge. Refer to the Organizational Strengths section for a discussion of white boards and blue folders.

Diabetes and Atypical Antipsychotic Medications – Patients Were Appropriately Screened and Managed

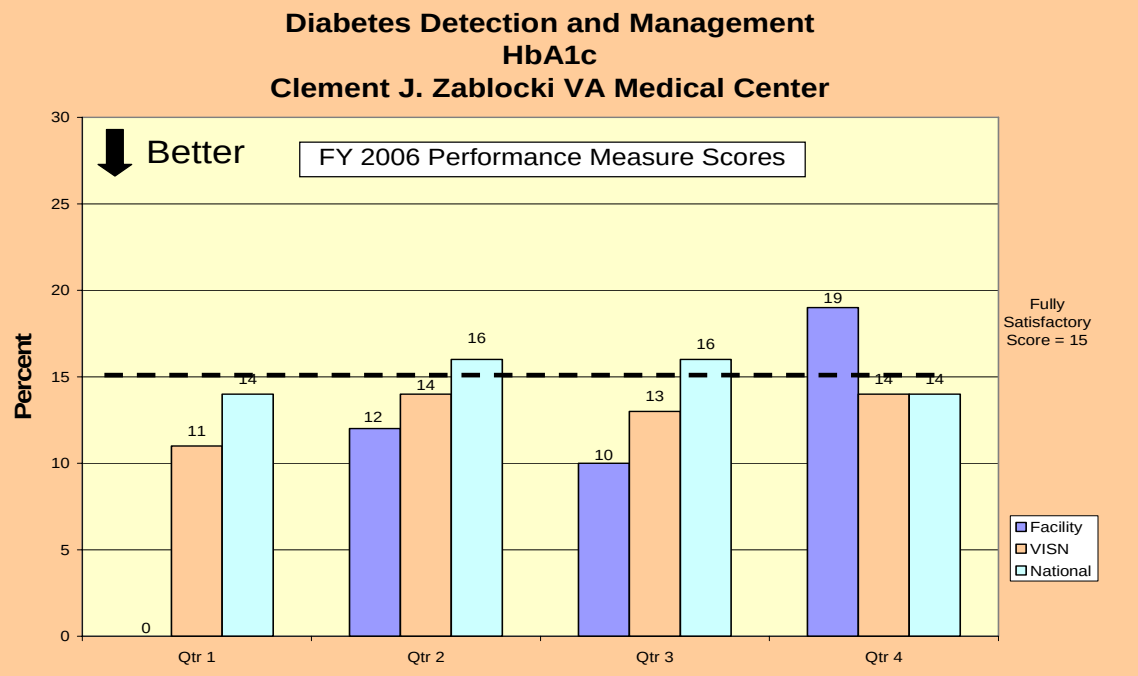
The purpose of the review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that: (a) diabetic patients' hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; (b) blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and (c) low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dL).

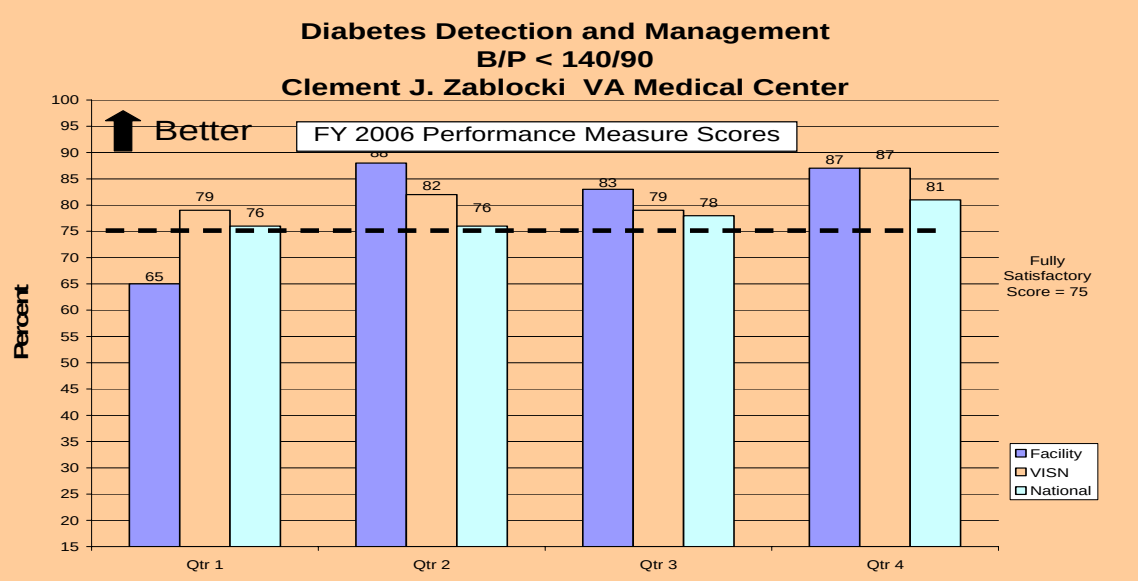
To receive fully satisfactory ratings for these diabetes performance measures, the medical center must achieve the following scores:

- HbA1c greater than 9 percent (poor glycemic control) – 15 percent of the patient population (lower percent is better)
- Blood pressure less than or equal to 140/90mmHg – 75 percent of the patient population (higher percent is better)
- LDL-C less than 120mg/dL – 79 percent of the patient population (higher percent is better)

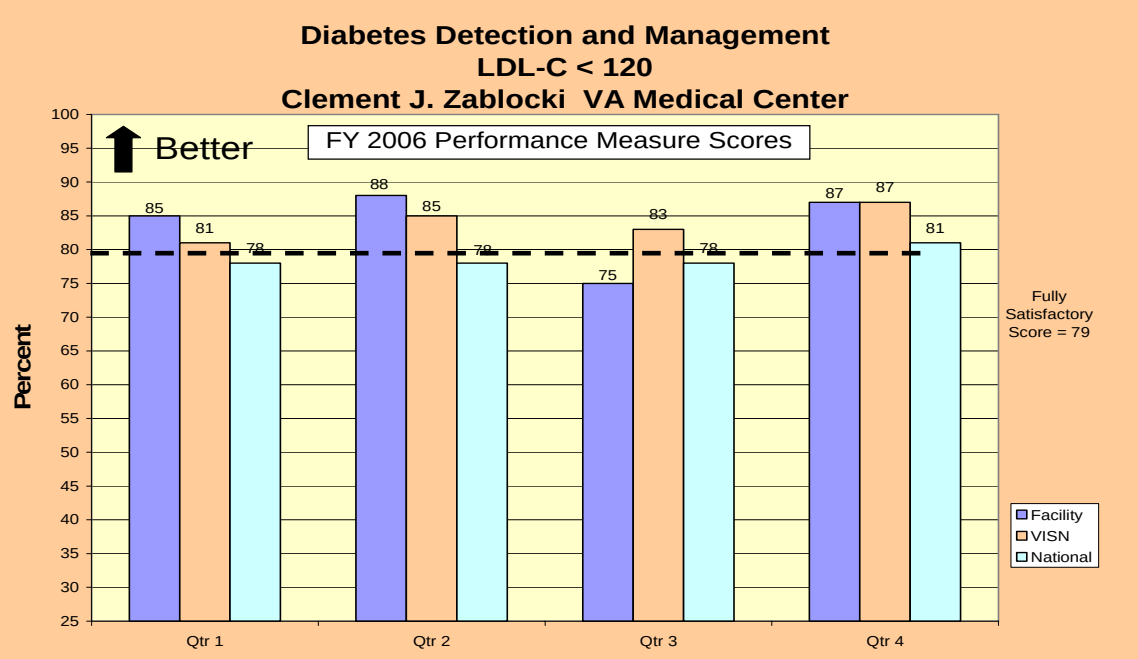
Although the medical center did not consistently meet VHA performance measures for HbA1c glycemic values, blood pressure monitoring, or cholesterol control for all 4 quarters in FY 2006 (see charts on following two pages), clinical providers informed us that they immediately evaluate less than satisfactory scores through the Performance Monitoring Program (PMP). The PMP reviews 100 percent of primary care patients against selected performance measures. When less than satisfactory performance scores are achieved, interventions are immediately taken for corrective action. These interventions include, but are not limited to, provider feedback, staff education, and intense reviews of outliers.



Note: The medical center had no patients meeting the criteria for Qtr 1.



Legend: *< = Less than*
B/P = blood pressure



Legend: ***< = Less than***

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than or equal to 110 mg/dL. Patients with FBG values of more than 110 mg/dL but less than 126 mg/dL should be counseled about prevention strategies (calorie-restricted diets, weight control, and exercise). A FBG value of more than or equal to 126 mg/dL on at least two occasions is diagnostic for diabetes.

We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days in FY 2005. Three patients in the sample were diagnosed with diabetes. One of the diabetic patients had an HbA1c value greater than 7 percent. In response, a medication change was implemented for optimal glycemic control. Another diabetic patient had an elevated LDL-C level; however, medications have been prescribed, and the patient's LDL-C level was improving. Of the 10 non-diabetic patients, appropriate education and screenings were documented in the medical records.

Quality Management Program – Program Was Comprehensive and Effective

To evaluate QM activities, we interviewed the medical center Director, Chief of Staff, Associate Director for Patient Care Services, and QM personnel, and we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following areas:

- QM and performance improvement committees, activities, and teams.

- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- Utilization management (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.
- Medical record documentation reviews.
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Restraint and seclusion usage reviews.
- Advanced clinic access reviews.
- Efficient patient flow reviews.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps. These steps were consistent with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards and included:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis with established goals and benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We also evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process, and we reviewed mortality analyses to determine the level of facility compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation.

VA Community Based Outpatient Clinics – Patients Received the Same Standard of Primary Care and Mental Health Services at the Cleveland CBOC and Medical Center

The purpose of the review was to assess the effectiveness of CBOC operations and VHA oversight to determine whether CBOCs are in compliance with selected standards of operations, such as patient safety, QM, credentialing and privileging, and the emergency management plan.

We interviewed key employees at the medical center and at the Cleveland CBOC and reviewed documentation and self-assessment tools on descriptions of services provided, including warfarin[2] clinic services. We determined that the medical center and the CBOC warfarin clinics were both managed by a pharmacist, with primary care physician oversight, and maintained the same standards and expectations. Patients received education from a pharmacist before they received their first dose of warfarin. Patients' laboratory values and follow-up care were managed by a pharmacist, with primary care physician oversight. Patients received a handbook with a toll-free telephone number to help facilitate prompt reporting of new medications or other vital information.

The CBOC environment of care inspection revealed a clean facility that met JCAHO, HIPAA, and Life Safety Code requirements. The emergency management plan was current, and all clinical providers were educated in and knowledgeable about rendering emergency care to veterans. All clinical providers were certified in CPR. The automated electronic defibrillator was inspected, and functionality documentation was up to date. A review of three CBOC clinical providers' credentialing and privileging files and two CBOC nurses' official personnel folders showed that appropriate background screenings were completed.

[2] Medication used to prevent blood clots.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 26, 2006

From: Network Director, VISN 12 (10N12)

Subject: **Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin**

To: Director, Chicago Office of Healthcare Inspections, Office of Inspector General (54CH)

Attached please find the Combined Assessment Program Review response from VAMC Milwaukee. If anything additional is needed, please contact my office at (708) 202-8400. Thank you.

James W. Roseborough

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 26, 2006

From: Medical Center Director (695/00)

Subject: **Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin**

To: Director, Chicago Office of Healthcare Inspections, Office of Inspector General (54CH)

Attached please find the Combined Assessment Program Review from VAMC Milwaukee. If additional information is needed, please contact my office at (414) 384-5314. Thank you.

Glen W. Grippen

Director's 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 the identified infection control, patient privacy, and safety concerns are corrected.

Concur **Target Completion Date:** 3/31/07 – 10/1/07

a. Review refrigerator and freezer monitoring process. The facility will continue with environmental rounds and tracer activity to identify focus areas and provide immediate follow up. Facilities Management (FM) will install wireless temperature recording and alarming system. Both Nursing and FM will be expected to respond to alarms. Contract awarded 10/1/06. All units except Spinal Cord Injury (SCI) and Nursing Home Care Unit (NHCU) will be done 3/31/07; SCI and NHCU will be done 10/1/07.

b. Determine process for inspecting, repairing and/or cleaning patient care items with damaged surfaces. FM will replace torn commode seat by 1/15/07. FM will provide staff follow-up training on cleaning techniques by 12/31/06. SCI will review products that may be easier to clean. Review will be completed by 12/31/06. FM has replaced cracked pillow. Patient care items will be reviewed during environmental rounds and tracer activities (ongoing).

c. Eliminate rope-style emergency call system cords and assure that emergency call cords can be reached from floor level. FM will replace all porous pull cords with non-porous pull cords, and adjust to appropriate length by 1/31/07.

d. Monitor and clean patient food or medication refrigerator gaskets. The dirty or worn gaskets on the two patient medication refrigerators noted during the review have been cleaned and replaced. Issue will continue to be monitored and tracked during environmental rounds and tracer activities. Findings (if any) will be shared immediately with area leadership for follow up.

e. Review practice of placing potentially sensitive information near computer workstations, outside patient rooms, and in hallways outside offices. The Information Security Officer (ISO) will provide follow-up training to staff in patient care areas regarding computer information security by 1/31/07. ISO will review local policy on information security and on time-out of computers by 1/31/07. Nurse Managers of patient care areas will review clip boards to ensure they do not contain patient sensitive information by 1/1/07. This information will be validated during ongoing environmental rounds and tracers.

f. Secure (lock) clean and dirty utility rooms. FM will install locks on clean and dirty utility room doors (where needed) by 3/31/07.

g. Monitor security of medical carts. Medication carts are self-locking. One was found to be malfunctioning during review. Nursing will check all medication carts for appropriate functioning of locking mechanism by 1/31/07. Work area sweeps during environmental rounds and tracers will be ongoing.

h. Monitor security of cleaning supplies. FM has retrained housekeeping staff. NHCU managers and FM will continue to monitor staff performance (ongoing).

i. Assess Inpatient Mental Health Environment for potential risks. FM will replace light cover by 12/31/06. FM will fix ceiling panel so it is flush with ceiling by 1/15/07.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) CNH program activities are monitored by a local CNH oversight committee with the

required representation, (b) annual CNH inspection activities are completed by each member of the CNH Inspection Team, and (c) VA patients in CNH facilities receive VA staff visits and monitoring per policy.

Concur **Target Completion Date:** 1/31/07

a. Review and revise CNH Program Oversight Committee structure, annual inspection process and patient monitoring. VA Milwaukee will establish a local Community Based Programs Oversight Committee. This committee will be responsible for monitoring and reviewing all community based programs and related contacts requiring oversight as defined in the respective handbooks, including: Contract Nursing Home Care (CNHC), Purchased Home health Services/Homemaker Home Health Aide, Home Infusion, and Contract Adult Day Health Care (CADHC). This committee would also oversee progress towards community-based program performance measures, including Care Coordination/Home Telehealth, and Non-Institutional Care Workload. Committee membership would include multidisciplinary management-level representatives from social work, nursing, quality management, acquisitions, medical staff, and other key staff subject experts. The committee will meet at least quarterly, and will report to the Chief of Staff and Associate Director for Patient Care Services through the Medical Executive Committee. Completion date 1/31/07.

b. The full CNHC Inspection Team will meet at least monthly to complete the document-based review process and determine if designated facilities are in compliance with VA standards. All members will be expected to complete their portion of the review process in sequence with the full inspection team. Compliance with the review process will be monitored by the Community Based Program Manager, and will be reported to the Oversight Committee. Members who fail to complete their portion of the review process in a timely manner will be reported to their immediate supervisor for corrective action. Completion date 1/31/07.

c. Patients in contact nursing homes will receive follow-up visits in accordance with VHA Handbook 1143.2. The Community Based Program Manager will monitor completion of monthly visits and related documentation using a tracking tool. Monthly visits will be alternated between a social worker and a nurse, unless otherwise indicated in the patient's visit plan. Patients who meet Handbook criteria for less frequent visits will be identified in the tracking tool and will have appropriate care planning documentation in the medical record. Compliance with monthly follow-up visits will be reported on a quarterly basis to the Community Based Programs Oversight Committee. Completion date 1/31/07.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) clinical providers complete informed consents for cardiac catheterization procedures that are consistent with VHA policy, (b) all clinically active staff complete CPR education, and (c) management officials review and revise the current CPR policy to clearly reflect VHA policy.

Concur **Target Completion Date:** 1/31/07

a. Review process of informed consent for cardiac catheterization procedures. Chief of Staff will provide education to each cardiologist and cardiology resident regarding their responsibilities in obtaining and documenting informed consent. Monthly review of compliance with policy will occur on a random sample of consents until 100 percent compliance with documentation requirements is met. Chief of Staff will issue a Chief of Staff Information Bulletin to all clinical staff providing refresher education about their responsibilities of clinicians in obtaining and documenting consent by 1/31/07.

b. Provide education to all clinically active staff. All credentialed and privileged staff received cardiopulmonary resuscitation education packets during the week December 11, 2006. Individuals are expected to complete their education before January 15, 2007. The Chief of Staff Office is coordinating this effort, tracking compliance and will follow up to completion.

c. Review and revise current CPR policy to clearly reflect VHA policy. Chief of Staff Office is currently working to revise facility policy for discussion at Medical Executive Committee in January 2007. Anticipate publication prior to 1/31/07.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	John Brooks Judy Brown Paula Chapman Wachita Haywood Jennifer Reed Leslie Rogers

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 12 (10N12)
Director, Clement J. Zablocki VA Medical Center (695/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction and Veterans Affairs
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Russell D. Feingold and Herb Kohl
U.S. House of Representatives: Steve Kagen, Gwen Moore, Thomas Petri, and Paul Ryan

This report is available at http://www.va.gov/oig/publications/reports-list.asp.