Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center Walla Walla, Washington

Report No. 07-00990-172 **July 19, 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 healthcare is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of March 26–30, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Jonathan M. Wainwright Memorial VA Medical Center (the medical center), Walla Walla, Washington. 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 146 employees. The medical center is part of Veterans Integrated Service Network (VISN) 20.

Results of Review

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

- A retinal screening program for diabetics.
- Enhanced temperature monitoring for cold storage areas.

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

- Patient satisfaction survey results.

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

- Strengthen the QM Program by ensuring that corrective action plans are implemented and by performing all required reviews.
- Ensure that business rules governing patient health records comply with Veterans Health Administration (VHA) policy.
- Address identified environment of care (EOC) findings.
- Ensure that all clinical staff at the community based outpatient clinic (CBOC) maintain current cardiopulmonary resuscitation certifications.

This report was prepared under the direction of Ms. Julie Watrous, Director, Los Angeles 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 9–14, 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 medical center is located in Walla Walla, WA, and is part of the VA Northwest Network, VISN 20. It serves a veteran population of about 63,000 in a primary service area that includes 14 counties located in southeastern Washington, northeastern Oregon, and southwestern Idaho. The medical center also provides outpatient care at CBOCs located in Richland and Yakima, WA, and Lewiston, ID.

Programs. The medical center provides primary care, inpatient behavioral health care, long-term care, and residential behavioral health and substance abuse treatment. Acute inpatient medical/surgical and subspecialty care are provided through referral to either VISN 20 tertiary care facilities or non-VA community facilities. The medical center operates 9 inpatient beds, 30 nursing home beds, and 22 residential beds.

Affiliations. The medical center is affiliated with Washington State University, Walla Walla College, and Walla Walla Community College and provides training in several programs, including nursing, audiology, and social work. Other affiliations include Pacific University College of Optometry, Couther College of Optometry, and the Illinois College of Optometry.

Resources. In fiscal year (FY) 2006, the medical center's expenditures totaled $46 million. Staffing in FY 2006 was 340 full-time employee equivalents (FTE), including 12.6 physician and 48.4 registered nurse FTE.

Workload. In FY 2006, the medical center treated 14,315 unique patients and provided 1,072 inpatient days. The inpatient care workload totaled 378 discharges, and the average daily census, including nursing home patients, was 26.9. Outpatient workload totaled 112,638 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 clinical areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following five activities:

CBOC	EOC
Business Rules for Veterans Health Information Systems	Patient Satisfaction Survey Results
	QM

The review covered medical center operations for FYs 2006 and 2007 through March 31, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we also provided fraud and integrity awareness training to 146 employees. This training 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.

Results of Review

Organizational Strengths and Reported Accomplishments

Retinal Screening Program for Diabetics

The medical center staff analyzed missed appointments and found that only 40 percent of diabetic patients who needed annual retinal screening actually presented for these screening appointments. As a result, the medical center participated in a VHA pilot program that provided decentralized retinal screening for diabetics. The program used a retinal camera operated by a certified retinal screener, and three sites participated, including the medical center and two of the CBOCs. Prior to the pilot program, this screening was only available at the medical center. Due to the teamwork of the optometrist and retinal screener, the medical center's diabetic retinal screening performance improved to 85 percent. This successful pilot experience was the basis for the retinal screening program implemented throughout VISN 20.

Enhanced Refrigerator and Freezer Temperature Monitoring

The medical center implemented an automated temperature monitoring system to improve responses when any refrigerator or freezer temperature reading is outside the optimal range. Temperatures that are too high or too low can damage medications, lab reagents, and other products, potentially causing patient injuries. The system monitors approximately 65 refrigerators and freezers at the medical center and at all of the CBOCs. The system's alert notification alarms are monitored at all times by medical center staff.

In addition to implementing the monitoring system, the medical center purchased special drug storage refrigerators for all drug dispensing locations. The refrigerators are designed to prevent freezing and to rapidly return temperatures to the preset optimal range in high use areas where the doors are opened frequently.

Opportunities for Improvement

Quality Management

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

The QM program was generally effective in providing oversight of the quality of care in the medical center. Appropriate review structures were in place for 10 of the 14 program activities reviewed. However, we identified four areas that needed improvement.

Action Plans. We found that staff analyzed data in all program areas reviewed. However, we did not find evidence of corrective action plans to address identified problems in several areas, including patient complaints, utilization management, and advanced clinic access. Medical center managers need to decide how the data analyses will be reported and to ensure that specific corrective actions are documented and implemented when problems are identified.

Aggregate Root Cause Analysis. During FY 2006, the annual aggregated root cause analysis (RCA) of patient falls had not been completed, as required. Medical center managers need to ensure compliance.

National Patient Safety Goals. We noted only partial compliance with three required goals: (1) improve the safety of using medications, (2) accurately and completely reconcile medications across the continuum of care, and (3) reduce risk of patient harm resulting from falls. Medical center managers need to ensure implementation of action plans to accomplish these goals.

Medical Record Quality Reviews. Clinicians had reviewed samples of medical records to assess the presence and thoroughness of some items, such as informed consents and pain assessments. However, there was no systematic review process in place for other required items, such as consults and problem lists. VHA directives and accreditation standards require that facilities have a systematic medical record quality review process.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that corrective action plans be documented and implemented when problems are identified in QM review processes.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the Patient Safety Manager completes annual aggregated patient fall RCAs and that the Patient Safety Manager coordinates implementation of action plans to meet all national patient safety goals.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the Health Information Management Services (HIMS) Chief coordinates a comprehensive medical record review process that meets all applicable requirements.

The VISN and Medical Center Directors concurred with the findings and recommendations and reported that they will take actions, which will include development of a standardized template for committee meetings to track the status of

committee actions. The Quality Manager will ensure that required aggregated reviews are completed and national patient safety goals are met. Also, a medical record review process is under development and will be reported to the Executive Committee of the Medical Staff (ECMS). The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Business Rules for Veterans Health Information Systems

The purpose of this review was to determine whether business rules governing the electronic health record comply with VHA policy. The health record includes both the electronic medical record and the paper record. It includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added to the record as addendums to the original note or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the medical record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. OI also recommended that the ability to edit signed records be limited to the medical center's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and medical center policies and interviewed the HIMS Chief and clinical application coordinators. We reviewed 239 business rules governing clinical documents and found 16 that allowed editing of signed notes or records, in violation of VHA policy. In addition, we found two rules that were not consistent with VHA policy, in that they authorized the Clinical Application Coordinator and/or transcriptionist to reassign documents. Reassignment is an option used when the correct data is entered on the wrong patient.[1] During our review, program staff deleted rules deemed inappropriate and initiated a review of existing business rules.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires HIMS staff to conduct a comprehensive review of all business rules to ensure compliance with VHA policy and to perform a periodic review of all business rules.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that HIMS staff delete business rules no longer in use.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will take actions, which will include a review of all business rules to ensure compliance with VHA policy and deletion of rules no longer in use. The target

[1] Handbook 1907.01: *Health Information Management and Health Records*, issued August 25, 2006, requires the HIMS manager or the Privacy Officer to approve reassignment of completed documentation.

date for completion is August 15, 2007. An annual 4th quarter review will be conducted and a report submitted to the ECMS. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center complied with selected infection control (IC) and drinking water safety standards and maintained a safe and clean patient care environment.

We found that the medical center had established appropriate policies related to management of patients with multi-drug resistant organisms (MDROs). We reviewed five MDRO patients' medical records and found that all five contained the appropriate electronic clinical posting to alert staff.

We reviewed relevant documents related to the oversight of the drinking water system. We found that managers appropriately conducted and monitored monthly testing of drinking water.

Managers informed us that the housekeeping department had recently hired four new employees. During our inspection of the medical center, employees confirmed that cleanliness was a concern. We identified improvement opportunities in the following areas:

General Cleaning Practices. We found several housekeeping issues that managers needed to address:

- Dirty and damaged furniture in the Behavioral Health building needed to be repaired or replaced.
- Bathrooms in the Nursing Home Care Unit required thorough cleaning.
- Staff break rooms throughout the medical center needed to be monitored for cleanliness.

Security of Patient Information. In the Ambulatory Care Clinic, in areas accessible to the public, we found open boxes that contained patient information that needed to be shredded. Federal law and VHA policy require that patient information be secured.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that appropriate actions are taken to correct and monitor identified cleanliness issues.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that patient information needing to be shredded is secured.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that actions will be taken. New housekeepers were hired, and staff was reminded to maintain a clean and safe work place. Dirty and damaged furniture has been cleaned or discarded, and new furniture is being ordered. Two locking bins for disposal of patient information have been purchased, and additional bins will be purchased and on station by July 1, 2007. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Community Based Outpatient Clinic

The purpose of this review was to determine if the outpatient clinic in Yakima: (1) complied with selected VHA standards of CBOC operation, (2) improved patient access to health care services, and (3) maintained the same standards of care for providing mental health services and anticoagulation therapy as the medical center. We interviewed key personnel and patients; and we evaluated policies, procedures, and other relevant documents.

We found that the CBOC provided quality care and was compliant with the VHA standards of operation reviewed. The clinic had improved access, timeliness, and convenience of services. Patients were satisfied with all aspects of care. Mental health treatment was provided by clinicians at the CBOC, and the standards of care for providing anticoagulation therapy were the same throughout the medical center and CBOC.

We also found complete and current documentation for physician and nurse licenses, background checks, and provider privileging. A facility policy outlined appropriate emergency protocols, and CBOC personnel appeared to be knowledgeable of these procedures. However, CBOC personnel did not have current cardiopulmonary resuscitation certifications, as required.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires clinical staff to maintain current cardiopulmonary resuscitation certifications.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that actions have been taken, which included recertification of identified clinical staff, implementation of a new policy, and designation of the responsibility to maintain a schedule for required staff training. The improvement plans are acceptable, and we consider the recommendation closed.

Other Review Topic

Patient Satisfaction Survey Results

The purpose of this review was to assess the extent to which the medical center used the results of VHA's patient satisfaction survey to improve care, treatment, and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Executive Career Field Performance Plan for FY 2006 established that 77 percent of ambulatory care patients and 76 percent of discharged inpatients must report overall satisfaction of "very good" or "excellent" in order to meet or exceed target goals for VHA's Survey of the Health Experiences of Patients (SHEP). The table below shows the national, VISN 20, and the medical center's outpatient survey results. The number of inpatient responses was too low for comparison.

OUTPATIENT SHEP RESULTS

FY 2006 Quarter 4	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.1	77.9	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
VISN	82.8	79	95.1	73.6	84.6	75.9	82.4	57.8	82	79.1	83.4
Medical Center Clinics	83.7	90.8	93.6	70.4	83	79.6	*	71.7	77.7	*	84.6

Legend: ***** Indicates less than 30 respondents

The medical center's managers shared the results with employees, as expected. Managers had implemented action plans to improve patient satisfaction with education and information and pharmacy pick-up. We found the action plans acceptable and did not make any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2007

From: Network Director, VISN 20 (10N20)

Subj: VISN 20 Response – VAMC Walla Walla CAP Draft Report

To: Director, VHA Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA.

2. If you have any questions regarding this report, please contact Steve Bird, Patient Safety Coordinator, at (509) 525-5200, x22243.

(original signed by:)
Dennis M. Lewis, FACHE

Attachments

Appendix B

Medical Center Director Comments

JONATHAN M. WAINWRIGHT MEMORIAL VA MEDICAL CENTER

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

Quality Management

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that corrective action plans be documented and implemented when problems are identified in QM review processes.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the Patient Safety Manager completes annual aggregated patient fall RCAs and that the Patient Safety Manager coordinates implementation of action plans to meet all national patient safety goals.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the Health Information Management Services (HIMS) Chief coordinates a comprehensive medical record review process that meets all applicable requirements.

Concur with recommended improvement actions.

Corrective action plans be documented and implemented when problems are identified in QM review processes:

Planned Action: The Medical Center has initiated a review of committee minutes with the goal of using a standardized template to improve the flow and accuracy of topic discussion and tracking of committee actions. Recommendations for improvement are anticipated by **June 1, 2007**, with approved recommendation expected to be implemented by **July 1, 2007.**

Patient Safety Manager completes annual aggregated patient fall RCA's:

Planned Action: The Quality Manager has reviewed the current requirements for completion of the Aggregate Root Cause Analysis (RCA) for patient falls and will work with the Patient Safety Manager to ensure the RCA is initiated on

September 17, 2007, and completed by **November 30, 2007**, per the National Center for Patient Safety aggregate review schedule**.** Aggregate data from previous year will be rolled over and used in this year's RCA.

Patient Safety Manager coordinates implementation of action plans to meet all national patient safety goals:

Planned Action: The Quality Manager has reviewed the current Joint Commission National Patient Safety Goals (NPSG) and will work with the Patient Safety Manager to ensure ongoing monitoring of the NPSG requirements and coordination of action plans as necessary.

In response to the specific findings, the following actions have been taken or are in progress:

The medical center has obtained and initiated the use of blank adhesive labels to label containers or syringes used for sterile water or other solutions that may be used for scope cleaning immediately following endoscopic procedures on **February 23, 2007**.

Nursing Home Care Unit Policy number 34 dated **March 20, 2007**, has been drafted and approved. It describes all of the elements of the LTC facility's fall reduction program. The policy provides expectations for assessments, reassessments, and guidelines for interventions based on fall risk assessment findings. The policy describes additional procedures for analyzing the effectiveness of the program.

Actual and close call fall events specific for the nursing home will be aggregated and analyzed in accordance with existing policy. Individual adverse fall events that result in major injury, as defined in existing policy, will have a Root Cause Analysis completed. Findings, recommendations, and actions from both reviews will be reported to appropriate facility committees for implementation and follow-up.

A draft policy outlining responsibilities and procedures for performing medication reconciliation has been prepared, and a meeting with the Chief of Staff and Associate Director for Nursing has been scheduled for **May 21, 2007**, for review and concurrence. Final policy concurrence is expected by **June 15, 2007**.

Health Information Management Services (HIMS) Manager coordinates a comprehensive medical record review process that meets all applicable requirements:

Planned Action: The HIMS Manager, in collaboration with the Chief of Staff, will identify all applicable requirements for the medical review process and report to the Executive Committee of the Medical Staff (ECMS) by **July 1, 2007.**

Business Rules for Veterans Health Information Systems

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires HIMS staff to conduct a comprehensive review of all business rules to ensure compliance with VHA policy and to perform a periodic review of all business rules.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that HIMS staff delete business rules no longer in use.

Concur with recommended improvement actions.

Conduct a comprehensive review of all business rules to ensure compliance with VHA policy:

Planned Action: The HIMS Chief has directed the CPRS Clinical Application Coordinators to identify and conduct a comprehensive review of all business rules for compliance with VHA Policy by **August 15, 2007.**

Perform a periodic review of all business rules:

Planned Action: The HIMS Chief has directed the CPRS Clinical Application Coordinators to conduct an annual comprehensive review of business rules and as necessary based on OI guidance, staff role changes or changes in facility services provided. Annual review of the business rules will be conducted during the **4th QTR** of each fiscal year. This report will be submitted to ECMS for inclusion on the recurring report calendar.

Delete business rules no longer in use:

Planned Action: The 16 inappropriate business rules identified during the OIG CAP were confirmed as deleted on **March 23, 2007**. Additional corrections or deletions will be made based on the outcome of the comprehensive review outlined above.

Environment of Care

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that appropriate actions are taken to correct and monitor identified cleanliness issues.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that patient information needing to be shredded is secured.

Concur with recommended improvement actions.

Appropriate actions are taken to correct and monitor identified cleanliness issues:

Planned Actions: Four new housekeepers have been hired and all have started working as of **April 30, 2007**. The housekeeping department supervisor reinforced on **March 29, 2007**, the need for housekeeping staff to follow established cleaning schedules for high use areas, e.g., NHCU bathrooms to ensure cleaning services are provided following periods of maximum use.

Immediately following the OIG CAP Exit Briefing, Department Managers and Supervisors were directed that it is their responsibility to ensure staff break rooms are monitored and maintained in a clean and safe manner and then again during the Directors Weekly meeting on **May 4, 2007.**

On **March 12, 2007**, the Medical Center increased the frequency of Environment of Care (EOC) rounds from twice a month to weekly. The Medical Center Policy MCM 06-SA-07 is being revised for concurrence on **June 1, 2007**, and will include strengthening of the existing Infection Control focus on cleanliness.

Furniture in the identified areas has been cleaned and sanitized or discarded. Requests for new furniture have been submitted and approved and are in the process of being ordered as of **April 27, 2007.** Additional inspection of furniture in other areas of the Medical Center has resulted in requests to replace all wardrobes and dressers in the NHCU resident rooms. This additional request was approved by the Projects and Space Committee on **April 19, 2007**, and by the Resources Committee on **April 26, 2007.**

Patient information needing to be shredded is secured:

Planned Action: The Ambulatory Care Manager on **March 30, 2007**, discussed with staff the need to keep all unattended office locations, where personally

protected information is present, secured. Additionally, the Medical Center identified and purchased on **April 25, 2007**, two locking bins for temporary storage of documents to be shredded. The bins arrived on **May 2, 2007**, and have been evaluated and approved by clinic staff as a replacement for the current shred bins that cannot be secured. It is anticipated that additional new bins for all clinic work stations will be purchased and on station by **July 1, 2007**.

Community Based Outpatient Clinic

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires clinical staff to maintain current cardiopulmonary resuscitation certifications.

Concur with recommended improvement actions.

Require clinical staff to maintain current cardiopulmonary resuscitation certifications:

Planned Action: The two staff members identified during the OIG CAP review have been recertified as of **May 8, 2007**. Patient Care Policy 07-119 dated **March 21, 2007**, has been approved and established the responsibility for the clinical staff manager to schedule employees to attend BLS training, as required, to keep certification current and for arranging and providing for BLS process training. The policy also specifies responsibility for the Clinical Educator to organize BLS training for employees, maintain records of the training, and notify managers when BLS recertification is due.

Notification to clinical managers occurs on a quarterly basis, informing them of their responsibility to provide scheduled time for staff to complete recertification. The Clinical Educator schedules monthly BLS classes and provides information on sources for staff required to recertify in ACLS.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, RN, Director Los Angeles Healthcare Inspections Division (213) 253-5134
Acknowledgments	Daisy Arugay Michelle Porter Monty Stokes

Appendix D

Report Distribution

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