Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Wilkes-Barre VA Medical Center
Wilkes-Barre, Pennsylvania

Report No. 06-02663-218 **September 28, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of the review was to determine the validity of allegations of substandard patient care in the Emergency Department (ED), Primary Care Clinic, Nursing Home Care Unit (NHCU), and Intensive Care Unit (ICU) at the Wilkes-Barre VA Medical Center.

We did substantiate allegations that patient care in the ED had been deficient; however, the medical center had previously identified problems and had developed action plans to resolve the issues. We concluded that the action plans were reasonable and that VA Inspector General follow-up was warranted to ensure implementation of the medical center's plans.

We substantiated that changes in the operation of the Primary Care Clinic and walk-in clinic were not well coordinated or communicated with staff and patients.

We substantiated the allegation that walk-in patients, on occasion, did see doctors other that their assigned primary care providers. However, we did not substantiate the implication that this practice was inappropriate.

We did not substantiate the allegation that resident physicians were not properly supervised.

We did not substantiate the allegation that patients in the NHCU and ICU were not properly fed or cleaned due to a staff shortage or that elderly and frail patents in need of hospital care were routinely sent home without proper care.

We recommended that management ensure appropriate clinical staff participation in all decisions regarding patient care process changes and that patients be given advanced notice of all changes in their treatment regime.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 4 (10N4)

SUBJECT: Healthcare Inspection – Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania

Purpose

The VA Office of Inspector General, Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations pertaining to patient care issues in the Emergency Department (ED), Primary Care clinics, Nursing Home Care Unit (NHCU), and Intensive Care Unit (ICU) at the Wilkes-Barre VA Medical Center (the medical center). The complainants' allegations included denial of care, delay in diagnosis and treatment, inadequate training of ED staff, inadequate resident supervision, insufficient staffing, premature discharge from the NHCU and ICU, and poor communication.

Background

The medical center is a general medical and surgical facility consisting of 79 acute care beds, 105 nursing home beds, and 10 Substance Abuse Residential Rehabilitation Treatment Program beds. The medical center is part of Veterans Integrated Service Network (VISN) 4 and serves a veteran population of more than 201,221 in 19 counties in Pennsylvania and 1 county in New York.

On June 21, 2006, an anonymous complainant alleged that patients seeking treatment in the ED were being sent home without being triaged or scheduled to see a primary care provider. The complainant further alleged that nurses, primary care physicians, and clerks were not made aware of procedure changes regarding treatment of walk-in patients and that walk-in patients were not properly triaged because nurses were not properly trained. The complainant also alleged that patients were scheduled to see doctors other than their primary care physicians and that physicians were not supervising residents due to staffing shortages.

On July 13, 2006, a second anonymous complainant alleged that patients in the NHCU and ICU were not properly fed or cleaned and that elderly and frail patients were prematurely discharge due to staff shortages. The complainant alleged that management was informed of these problems but took no action.

Scope and Methodology

We conducted a site visit at the medical center from August 7–10, 2006. We interviewed senior managers and employees and reviewed pertinent medical center documents. We toured the ED, the NHCU, and the ICU and talked with patients and their families.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Emergency Department Denial of Care

We substantiated this allegation; however, the medical center had previously identified problems in the ED and had implemented action plans to resolve them.

On July 6, 2005, the medical center Director authorized an Administrative Board of Investigation (Board) to review allegations of irregularities in ED procedures. The Board issued their report on August 18, 2005, which included the following findings:

- The medical center lacked written criteria and a defined process for the disposition of veterans for care after triage.
- The discontinuation of the medication refill clinic increased the number of veterans requiring triage and reduced the ability to evaluate patients expeditiously.
- The ED lacked an onsite manager for the oversight of nursing care and coordination of day-to-day operations.
- Instances of inappropriate disposition of patients after assessment by a registered nurse in triage did occur.
- Delay in treatment probably did occur due to the diversion of veterans who were informed that there were no walk-in visits and due to staff unwillingness to address patients' concerns.
- Staff did not seem to follow the medical center policy on the management of pain. They frequently seemed to assume that even patients presenting with excruciating pain were just medication seeking.

Medical center managers recognized that the existing triage process for providing access to emergency care was ineffectual. The lack of criteria for the disposition of patients being triaged, the need for updated ED triage policies to reflect the operational processes,

the lack of an onsite ED manager, and the shortage of staff during peak activity in the ED area contributed to the problems.

In response to these findings, the following actions were taken:

- ED nurse manager hired in June 2006.
- Triage protocol developed and implemented in August 2006.
- Mandatory continuing education requirements for ED nurses established.
- Additional full-time employee equivalents (FTE) hired—nursing and professional staff.
- Proposed administrative action for an employee.

We concluded that improper care and treatment had occurred in the ED; however, corrective actions had been taken to address the problems. Processes are now in place to provide patients access to appropriate emergency care.

Issue 2: Staff Communication

We substantiated that there were breakdowns in staff communication.

The complainants alleged that nurses, primary care and ED physicians, and clinic clerks were not adequately informed about procedure changes regarding treatment of walk-in patients.

On May 1, 2005, medical center managers abruptly closed the walk-in clinic (also known as the Block Clinic) and the medication refill clinic. Staff told us that they were not involved in the decision-making process regarding these closures and that they were not given advance warning so that they could properly prepare themselves and patients. This resulted in confusion, misunderstandings, and misinterpretation of management actions and intentions. Some staff members reported that the only notice they received of the clinic closures was an e-mail sent on May 2, 2005 entitled "New Process for walk-in patients," which described the new process for routing patients when they report to the ED reception desk.

We concluded that staff were not included in the decision-making process regarding the clinic closures and that the closures were not coordinated on an organization-wide level. We further concluded that staff were not given advance notification of the closures so that they could properly notify patients.

Issue 3: Improper Referral of Care

We substantiated the allegation that on occasion, walk-in patients see doctors other than their primary care providers. However, we did not substantiate the implication that this was inappropriate.

According to VHA Directive 2006-031, *Primary Care Standards*, "primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." The directive instructs the medical center Director to ensure that primary care services meet standards of continuity, accessibility and timeliness, comprehensiveness, and coordination. Patients must be able to obtain medical advice when they seek it, whether for urgent problems, minor concerns, or chronic conditions. This need may take precedence over a patient's desire to see the same physician for every visit to the medical center.

In May 2006, medical center managers developed a policy that outlined the process for providing health care to walk-in patients and met the standards outlined in VHA Directive 2006-031. The policy addressed the changes needed to meet VHA goals of accessibility and timeliness by ensuring that walk-in patients are seen the same day. Primary care providers are encouraged to have several available slots open per day for walk-ins. However, if a particular provider does not have an open slot available, then another primary care provider with an open slot will see the patient. That provider will share clinical information with the patient's primary care provider to ensure coordination of care.

Efforts to improve communication between the ED and Primary Care were implemented. An ED nurse manager was appointed as the acting Utilization Review Nurse and in that role, had the opportunity for positive interaction with other departments outside the ED, including Primary Care.

We concluded that walk-in patients on occasion see primary care providers other than their own, and in emergent circumstances, they see ED physicians. However, this process was developed to ensure that patients are seen the same day. This new process also ensures that the medical center meets or exceeds expectations set by the VHA performance measurement system, which assesses clinical quality, veteran satisfaction, and efficiency.

Issue 4: Resident Supervision

We did not substantiate the allegation that resident physicians were not properly supervised.

The medical center issued a revised resident supervision policy dated August 9, 2005. The policy was revised as a result of an American College of Graduate Medical Education (ACGME) determination that resident physicians were being used for service in the Block Clinic in a manner that did not meet ACGME educational standards. The revised policy requires that medical center supervision of the residency program be monitored by the Performance Improvement (PI) Steering Committee, the Clinical

Competency Evaluation Committee, and the Medical Records Committee. The PI Steering Committee reviewed quarterly performance measures, including resident supervision/timely admission notes. For Fiscal Year 2005, the medical center met the fully satisfactory standards for documentation. The Clinical Competency Evaluation Committee ensured proper supervision of residents by providers. As part of the External Peer Review Program (EPRP), the Medical Records Committee reviewed the "Resident Supervision Report" and called for action from the respective service chiefs when a problem was identified.

Residency programs at the medical center ended in August 2007. The ACGME made this decision because the clinic did not have the proper case mix of patients to meet educational criteria. We concluded that residents were properly supervised and that the medical facility had sufficient processes in place to monitor resident supervision.

Issue 5: Intensive Care Unit and Nursing Home Care Unit Quality of Care

We did not substantiate the allegations that patients on the NHCU and ICU floors were not properly fed or cleaned due to an alleged shortage of staff or that elderly and frail patients in need of in-house care were are routinely sent home without proper care.

On August 7, 2006, we made an unannounced visit to the NHCU and ICU. Over the next 3 days, we made additional unannounced visits to the units, including off-shift visits. We interviewed patients, their family members, and staff, including Nutrition Service staff. Generally, we found that patients were clean and that their nutritional needs were being attended to. NHCU patients with dementia or geri-psych (geriatric-psychiatric) conditions present challenges to staff who assist patients attempting to perform activities of daily living (ADL), such as showering, shaving, and feeding. NHCU staff are sensitive to these patients' needs and give patients choices, when possible, to ensure that these tasks are accomplished as needed. ICU patients have their ADL goals determined by the complexities of their medical conditions. We did not find any evidence to indicate that ICU patients' ADLs were not properly attended to. Interviews with patients and their family members and our review of the patient advocate's complaint files did not identify any issues related to nursing care. Prior to our review, Nursing Service managers used the hours per patient day (HPPD) model to analyze staffing needs. Based on their results, additional Nursing Service FTEs were hired.

The medical center conducted a random review of 30 readmissions during the 1st and 2nd quarters of fiscal year 2006. Data analysis did not identify any significant patterns for specific providers or services or evidence of premature discharge or inappropriate outpatient follow-up. This review led to the establishment of a Readmission Review Panel, which is comprised of a primary care provider, an attending physician, a nurse manager, and a social worker. The panel reviews all readmissions within 30 days and

provides feedback and recommendations, as appropriate, to service chiefs. Service chiefs are required to develop and implement action plans for all recommendations. Utilization Review staff track action plans to completion and report effectiveness of actions to the Chief of Staff monthly.

We concluded that the number of NHCU and ICU staff at the medical center are sufficient to provide safe care and that patients are properly bathed and fed. We did not find any evidence that patients were prematurely discharged because of insufficient staff.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director includes appropriate clinical staff in all decisions regarding patient care process changes and that patients are given ample notice of all changes in their treatment regime.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendation of this inspection and provided acceptable improvement plans. (See Appendixes A and B, pages 7–9, 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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2007

From: Director, Veterans Integrated Service Network (10N4)

Subject: **Healthcare Inspection—Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania**

To: Director, Management Review Service (10B5)

1. The response provided by the VA Medical Center, Wilkes-Barre, PA, has my full endorsement. As noted in the draft report, issues 3, 4, and 5 were not substantiated.

2. Since the facility noted the concerns regarding the Emergency Department and authorized an Administrative Board of Investigation to review the concerns, it is felt that the results of the board, as well as the actions taken, signify this issue was addressed appropriately and resolved.

3. I support the actions taken for resolution of Issue 2, staff communication. Appropriate staff are involved in the decision-making process, and all staff are provided notification of pending changes. This information can then be communicated to patients.

4. If you have any questions, please contact Janice Boss, Medical Center Director, or Judith Zboyovski, VISN QMO/Planner.

(original signed by:)

MICHAEL E. MORELAND, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 3, 2007

From: Director, Wilkes-Barre VA Medical Center (693/00)

Subject: **Healthcare Inspection—Quality of Care Issues, Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania**

To: Director, Management Review Service (10B5)

Network Director, VA Healthcare – VISN 4 (10N4)

1. As noted in OIG's report, Wilkes-Barre VA Medical Center had self-identified Issues 1 and 2. The OIG acknowledged that Issue 1 has been met through changes in key leadership positions improvement and process improvement.

2. The following process improvements to enhance patient care in the Emergency Department (ED), including front line staff input, have been communicated to all involved parties and implemented:

* Appropriate clinical staff is included in all decisions involving patient care process changes. Staff is provided ample notification of all treatment regime changes, so they are able to communicate this information to patients.

* New ED signage clarifying location has been posted.

* ED clerks have been educated as to appropriate interaction with patients presenting for emergency care.

* Each ED patient is triaged by an ED nurse and, depending on urgency, is seen in emergency department or other clinical areas of the medical center that same day. No patient who has been triaged is sent home without being evaluated by a clinical provider.

* Physician and nurse hand-offs are required to be performed face-to-face.

* ED activity is reviewed at the Executive Leadership's morning meeting the next administrative workday where issues/ actions/resolutions are discussed.

3. Wilkes-Barre VAMC self-identified Issue 3 and appropriate action was taken. Issues 4 and 5 were not substantiated.

4. If you have any questions, please feel free to contact me at (570) 821-7204.

(original signed by:)

JANICE M. BOSS, M.S., CHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Gail Bozzelli, RN Washington DC Regional Office 202 565-8305
	Randall Snow, JD

Appendix D

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