Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02713-43

Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin

December 7, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings 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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Glossary

AD	advance directive
BSC	biological safety cabinet
C&P	credentialing and privileging
CAP	Combined Assessment Program
EN	enteral nutrition
EOC	environment of care
facility	William S. Middleton Memorial Veterans Hospital
FY	fiscal year
MEC	Medical Executive Committee
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 12, 2011.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Enteral Nutrition Safety
- Environment of Care
- Management of Workplace Violence

The facility's reported accomplishments were adopting the principles of the American Nurses Credentialing Center Magnet Recognition Program® and partnering with the Epilepsy Foundation of Southern Wisconsin to perform veterans outreach in rural Wisconsin communities.

Recommendations: We made recommendations in the following five activities:

Physician Credentialing and Privileging: Ensure that at the time of reprivileging, Medical Executive Committee meeting minutes document discussion of performance data. Ensure clinical privileges granted are appropriate to providers' practice settings.

Medication Management: Ensure that safe work practices, including changing outer gloves when re-entering the biological safety cabinet, are observed when handling hazardous drugs.

Registered Nurse Competencies: Ensure competency validation documentation is complete.

Quality Management: Ensure the Medical Records Committee analyzes the results of medical record quality reviews.

Coordination of Care: Ensure that all components of written advance directive notification are provided to patients and that notification is documented in the medical record.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through September 12, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the William S. Middleton*

Memorial Veterans Hospital, Madison, Wisconsin, Report No. 08-02600-100, March 24, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 70 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Magnet Recognition Program®

The facility adopted the principles of the American Nurses Credentialing Center Magnet Recognition Program® and achieved magnet status in January 2010. The components of the Magnet Model are:

- Transformational leadership
- Exemplary professional practice
- Empirical quality results
- Structural empowerment
- New knowledge, innovation, and improvements

Magnet designation recognizes health care organizations that provide excellence in nursing practice, and the facility's magnet recognition has resulted in high quality patient care and staff satisfaction.

Epilepsy Center of Excellence Receives Grant

The facility's Epilepsy Center of Excellence in partnership with the Epilepsy Foundation, Southern Wisconsin was awarded a $10,000 grant in January 2011 to perform veterans outreach in rural Wisconsin communities. Outreach efforts ensure that veterans, their family members, and their primary care physicians receive post-traumatic epilepsy symptom information. In addition, veterans receive services through the facility's Epilepsy Center of Excellence.

Results

Review Activities With Recommendations

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

Ongoing Professional Practice Evaluation. VHA requires that at the time of reprivileging, provider-specific performance data be collected and presented to the MEC for review and approval.[1] We found that MEC meeting minutes did not include discussion of performance data for any of the 10 applicable physician profiles reviewed.

Management implemented a process during the August 2011 MEC meeting to include documenting the discussion of provider-specific performance data. We reviewed the files of all 26 providers reprivileged in August and did not find documentation for 5 of the providers.

Setting-Specific Privileges. VHA requires that clinical privileges be specific for each clinical site.[2] We found that 13 of the 15 providers whose files we reviewed were granted privileges outside of their practice settings. For example, three community based outpatient clinic providers were granted privileges to perform procedures not supported by the community based outpatient clinic settings.

Recommendations

1. We recommended that at the time of reprivileging, MEC meeting minutes document discussion of performance data for all physicians.

2. We recommended that processes be strengthened to ensure that clinical privileges granted are appropriate to providers' practice settings.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1100.19.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the infusion clinic, and we interviewed employees. We identified the following area that needed improvement.

Safe Work Practices. The American Society of Health-System Pharmacists requires safe handling of hazardous drugs to minimize contamination and ensure staff and patient safety. All items needed for compounding drugs must be gathered before beginning work, which should eliminate the need to exit the BSC once compounding has begun. However, if it is necessary to exit and re-enter the BSC, contaminated outer gloves must be removed before touching supplies and new outer gloves must be donned before re-entering the BSC. We observed a pharmacy staff member exit the BSC to gather additional supplies and re-enter without changing outer gloves.

Recommendation

3. We recommended that safe work practices, including changing outer gloves when re-entering the BSC, be observed when handling hazardous drugs.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to perform their responsibilities. Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. Nine of the 12 RN competency folders did not contain sufficient evidence that core and unit/position-specific competencies had been validated.

Recommendation

4. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following area that needed improvement.

Medical Record Review. VHA requires that the facility's health record review committee provide oversight and coordination, including analyzing the results of medical record quality reviews.[3] We found that the Medical Records Committee did not analyze the results of medical record quality reviews.

Recommendation

5. We recommended that medical record review processes be strengthened to ensure that the Medical Records Committee analyzes the results of medical record quality reviews.

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and ADs in accordance with applicable requirements.

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following area that needed improvement.

Advance Directive Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[4] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.

13 of the records did not contain evidence of all components of written notification.

Recommendation

6. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Substance Abuse RRTP complied with selected Mental Health RRTP requirements.

We inspected the emergency department and medical and surgical units (4A, 4B, the coronary care unit, and 7B). We also inspected same day surgery, outpatient clinic 6E/F, and the Substance Abuse RRTP unit. The facility maintained a generally clean and safe environment, and the Substance Abuse RRTP complied with selected requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and

management of disruptive behavior training. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–18 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	12	
Community Based Outpatient Clinics	Rockford, IL Freeport, IL Janesville, WI Baraboo, WI Beaver Dam, WI	
Veteran Population in Catchment Area	120,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	87	
• **Community Living Center/Nursing Home Care Unit**	0	
• **Other**	0	
Medical School Affiliation(s)	University of Wisconsin School of Medicine and Public Health	
• **Number of Residents**	101	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$285	$264
• **Medical Care Expenditures**	$137	$150
Total Medical Care Full-Time Employee Equivalents	1,486	1,450
Workload:		
• **Number of Station Level Unique Patients**	30,237	38,855
• **Inpatient Days of Care:**		
o **Acute Care**	15,324	29,080
o **Community Living Center/Nursing Home Care Unit**	NA	NA
Hospital Discharges	2,233	4,445
Total Average Daily Census (including all bed types)	84.2	79.7
Cumulative Occupancy Rate (in percent)	77.96	73.77
Outpatient Visits	158,244	313,494

[5] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Require that clinical privileges granted to contractors do not extend beyond the contract period.	The medical staff privileges form was modified to indicate the type of appointment granted. C&P staff maintain an electronic tracking log to ensure that granted privileges coincide with the contract period.	Y	N
EOC			
2. Correct identified safety deficiencies.	All safety deficiencies were corrected: • Nutrition and Food Service perform daily sweeps when restocking refrigerators. • Pharmacy technicians check for expired medications monthly. • Oxygen tank storage areas are clearly delineated with signage that indicates full or empty tanks. • All employees are reminded to keep the environment safe and free of sharp objects. Environmental safety is monitored weekly during EOC rounds.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
3. Correct identified infection control deficiencies.	Infection control deficiencies were corrected. Items with torn coverings are replaced in accordance with the standard operating procedure for replacement of equipment, supplies, and other material related to patient care.	Y	N
4. Require that patient care equipment receive preventive maintenance at the required intervals.	Patient care equipment receives preventive maintenance at required intervals.	Y	N
Coordination of Care			
5. Require that consultation requests are acted on within the facility's or service's defined timeframes.	Policies are in place to define timeframes for consultation requests, and they are provider specific.	Y	N
6. Require that discharge documentation accurately reflect active outpatient medications.	The process has changed related to pharmacy medication reconciliation at time of discharge. The patient education list is used for the discharge summary, and the medical resident signs it. Pharmacy monitors the compliance rate monthly.	Y	N
Emergency Department Operations			
7. Require clinicians to document inter-facility transfers in accordance with VHA policy.	Templates were developed for inter-facility transfers, and staff were educated on use of the templates. Current monitors indicate consents and templates are being consistently used.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Pharmacy Operations			
8. Require that monthly inspections are completed for all areas where controlled substances are stored.	Controlled substance inspections are conducted monthly in accordance with VHA policy.	Y	N
9. Require that deficiencies identified in the annual pharmacy security assessments are corrected.	Physical Security Assessment deficiencies have been corrected. Cameras were installed in the vault and are operational, security mesh has been added to windows that are less than 40 feet from ground level, and the inpatient pharmacy has a local audible alarm.	Y	N
10. Require frequent housekeeping service in the inpatient pharmacy, and repair ceiling leaks in the outpatient pharmacy.	Inpatient pharmacy reconstruction has been completed, and the ceiling leaks in the outpatient pharmacy were repaired.	Y	N

VHA Satisfaction Surveys

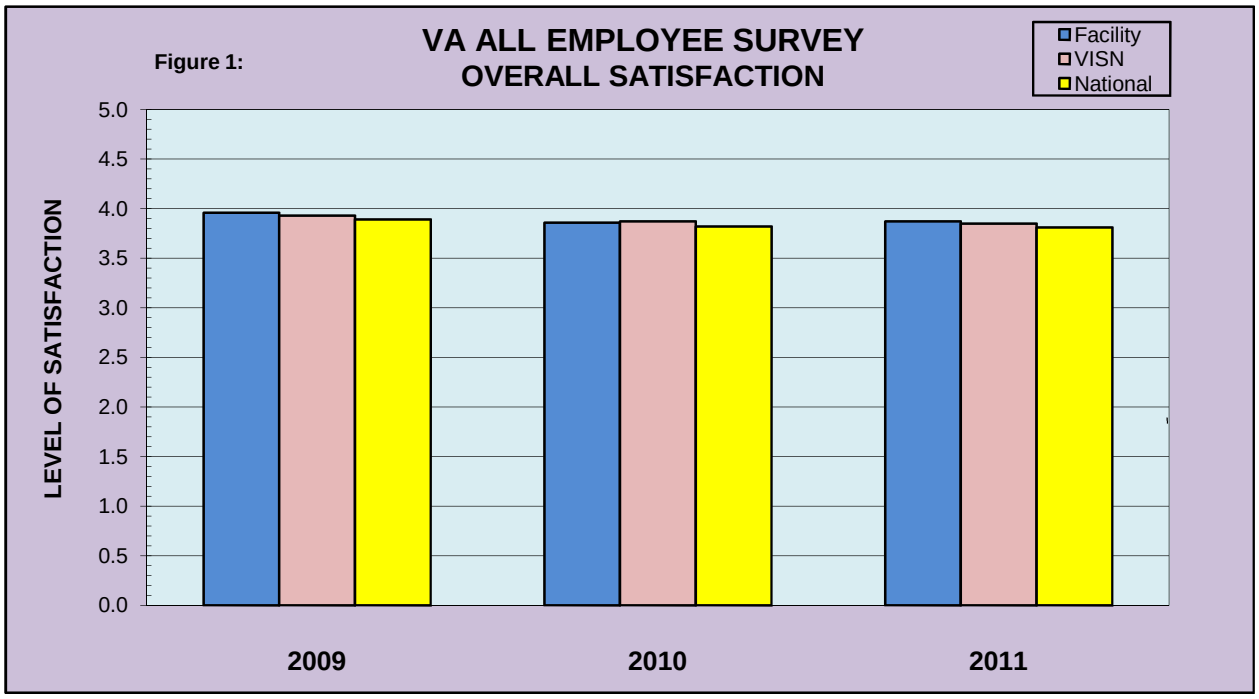
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	80.8	57.6	59.5	79.5	59.8	61.0
VISN	66.8	54.0	56.9	67.2	58.6	59.4
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[6] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[7]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	15.4	10.3	12.0	21.0	25.6	17.4
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[6] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[7] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 21, 2011

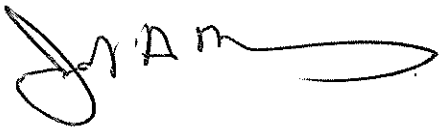
From: Director, VA Great Lakes Health Care System (10N12)

Subject: **CAP Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.



Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 18, 2011

From: Director, William S. Middleton Memorial Veterans Hospital (607/00)

Subject: **CAP Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI**

To: Director, VA Great Lakes Health Care System (10N12)

1 Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VAMC Madison (607).

2 I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

Deborah A. Thompson

DEBORAH A. THOMPSON

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 at the time of reprivileging, MEC meeting minutes document discussion of performance data for all physicians.

Concur

Target date for completion: December 31, 2011

Professional standards board (PSB) meeting minutes include performance data, i.e. OPPE and FPPE data, for each provider whether newly privileged or re-privileged. Inclusion of the data for all privileged providers began in September 2011. The conclusion of the FPPE period is also clearly delineated in PSB minutes, indicating start date for OPPE data collection. The PSB information is discussed at MEC, and documented in the MEC minutes. A review of October, November and December 2011 MEC minutes is planned to ensure documentation compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that clinical privileges granted are appropriate to providers' practice settings.

Concur

Target date for completion: May 31, 2012

Clinical privilege forms will be revised to insure that the clinical privileges granted are appropriate to the practice settings. Forms will be reviewed and approved at the January 2012 MEC. Privileging packets to be sent out in the month of February (2012) will include the newly revised privileging forms. Will review 20% of documents returned to the C&P office in May 2012 (90-day turn-around time for packets to go out and be returned) to ensure that revised forms were used and understood by end user (i.e. provider requesting privilege).

Recommendation 3. We recommended that safe work practices, including changing outer gloves when re-entering the BSC, be observed when handling hazardous drugs.

Concur

Target date for completion: March 1, 2012

The Medication Use Policy (Hospital Memorandum No.011-15, Attachment G: Handling of Antineoplastic Drugs, Appendix A: Preparation of Antineoplastic Drugs) will be modified to include a citation of Safe Work Practices, to include the gloving process

when exiting and re-entering the BSC. Pharmacy personnel authorized to prepare chemotherapy will receive targeted education on Safe Work Practices when exiting and re-entering the BSC. A Chemotherapy Competency Checklist will be performed weekly on 20% of pharmacy personnel authorized to prepare chemotherapy will demonstrate 100% compliance with outer glove practices. Weekly monitors will be reduced to quarterly monitors once there has been three consecutive months of 100% compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

Concur

Target date for completion: March 31, 2012

Nursing service will standardize forms for validating and documenting initial and annual nursing competency assessments (i.e. Nursing Proficiency Inventory and Annual Competency Checklist.) Nurse Managers will be educated relative to new forms and proper completion of competency assessment documents. Monthly audits will be done of 10% of all nursing employee folders with compliance threshold of 90% for two months post nurse manager education. Once compliance of 90% is met for two consecutive months, we can reduce to quarterly reviews.

Recommendation 5. We recommended that medical record review processes be strengthened to ensure that the Medical Records Committee analyzes the results of medical record quality reviews.

Concur

Target date for completion: March 31, 2012

The Medical Record Committee (MRC) will review the quality data report from the monthly Medical Record Review sub-committee at each scheduled MRC meeting. Quality data will be tracked and trended over time. Identified issues from data analysis will be forwarded to respective service chiefs through the Chief of Staff's office. The process of addressing identified action items will be reflected in the meeting minutes, utilizing the standardized meeting minute format. This format includes: discussion/conclusion, recommendations/actions, an assignment of responsible parties, and when and where follow-up reporting will occur until the closure of the issue. When an issue is identified and then closed, the complete documentation will be recorded in the meeting minutes to notate the compliance or evidence/reasoning for the closure. The MRC meeting minutes are reviewed and discussed at the MEC. Minutes will be audited on a monthly basis to ensure analysis of medical record quality reviews has been done and is reflected in the minutes until there are three consecutive months with analysis discussion documented.

Recommendation 6. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that notification is documented in the medical record.

Concur

Target date for completion: March 31, 2012.

AD discussion note template was modified to ensure that all components of written AD notification can be documented in the medical record. In compliance with the hospital AD policy every patient will be notified of AD and those patients will not be discriminated against whether they complete AD or not; that patients are screened for AD, and that every inpatient will be seen to discuss AD if they are medically/cognitively able to do so. Monthly chart reviews will be done on 50 admissions with a compliance threshold of 95% that all components of AD notification will be documented. Monthly monitor will be reduced to quarterly after three consecutive months of 95% compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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