Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01877-25

Combined Assessment Program Review of the Wilkes-Barre VA Medical Center Wilkes-Barre, Pennsylvania

November 7, 2012

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

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Wilkes-Barre VA Medical Center
FY	fiscal year
HF	heart failure
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
PI	performance improvement
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA

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 June 25, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following activities:

- Medication Management
- Moderate Sedation
- Nurse Staffing

The facility's reported accomplishments were the addition of a cardiac catheterization and electrophysiology suite and a system redesign project to reduce heart failure readmissions.

Recommendations: We made recommendations in the following seven activities:

Colorectal Cancer Screening: Notify patients of positive screening test results, diagnostic test results, and biopsy results within the required timeframe, and document notification. Ensure patients with positive screening test results receive diagnostic testing within the required timeframe.

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up within 7 days of discharge, and monitor compliance. Offer mental health services at least one evening per week. Ensure attempts to follow up with patients who fail to keep their mental health appointments are initiated and documented.

Polytrauma: Provide treatment plans to polytrauma outpatients and/or their families.

Environment of Care: Ensure patient care areas and fall mats are clean. Store clean and dirty equipment separately. Secure sensitive patient information displayed on computer screens.

Quality Management: Document final summary notes for ethics consults pertaining to active clinical cases in the electronic health records.

Point-of-Care Testing: Complete the actions required in response to critical test results. Clean and maintain glucometers in accordance with the manufacturer's recommendations.

Coordination of Care: Ensure medications ordered at discharge match those listed on patient discharge instructions.

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 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through June 28, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania,* Report No. 11-01298-268, September 1, 2011).

During this review, we presented crime awareness briefings for 209 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 234 responded. We shared survey results with facility managers.

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

Cardiac Catheterization and Electrophysiology Suite

The facility renovated a 12,000 square foot area for a state-of-the-art hemodialysis (a procedure used for patients with kidney failure) and cardiac testing suite. This setting provides sophisticated equipment that is fully integrated with the EHR system, allowing procedure reports to be immediately available to providers. Services have been extended to other VA facilities, enabling those patients access to health care providers closer to home.

HF System Redesign

To reduce the high rate of readmission among HF patients, a multidisciplinary team began to analyze and identify process issues in October 2011. Over time, the team formulated solutions and implemented policies to address patients' needs from admission to discharge. One of the improvements included COC among pharmacy, care coordination/home telehealth, nutrition, primary care, and cardiology staff. The facility also established an HF clinic, supervised by a cardiologist, to provide focused and timely care to these complex patients. The team tracks all HF patients admitted to acute care and reviews any patient readmitted within 30 days to identify any missed opportunities. In the 1st quarter of FY 2012, the facility had no HF readmissions and continues to remain below the HF readmission benchmark of 25 percent.

Results

Review Activities With Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[1] Three patients' EHRs did not contain documented evidence of timely notification.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[2] Two of the 12 patients who received diagnostic testing did not receive that testing within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[3] Six of the 12 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2007-004.
[3] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[4] Of the seven patients who had a biopsy, five EHRs did not contain documented evidence of timely notification.

Recommendations

1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

2. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

3. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

4. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2007-004.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 31 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
X	Outpatient MH services were offered at least one evening per week.
X	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[5] Eight patients did not receive the required outpatient MH follow-up.

Availability of MH Services. VHA requires that facilities offer MH services at least one evening per week.[6] The facility did not offer evening MH services.

Contact Attempts. VHA requires MH employees to document efforts to follow up with patients who do not keep scheduled MH appointments.[7] Three of the nine EHRs of patients who failed to keep their scheduled MH appointments did not include documentation of follow-up attempts.

Recommendations

5. We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within 7 days of discharge and that compliance be monitored.

6. We recommended that the facility offer MH services at least one evening per week.

[5] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[6] VHA Handbook 1160.01.
[7] VHA Handbook 1160.01 and VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

7. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 4 EHRs of patients who received outpatient polytrauma services, and 8 staff training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific treatment plan developed and provided to them and/or their families.[8] Although three of the four outpatients had treatment plans, none of the three EHRs reflected that the plans were provided to the outpatients or their families.

Recommendation

8. We recommended that processes be strengthened to ensure that treatment plans are provided to polytrauma outpatients and/or their families.

[8] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

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.

We inspected two inpatient units (medical/surgical and MH), two CLCs, the emergency department, the same day procedure unit, and four outpatient clinics (dental, infusion, oncology, and SCI). Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
X	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medication safety and security requirements were met.
X	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The JC requires that areas used by patients are clean. On one inpatient unit, we found patient rooms with dirty patient fall mats, heavily stained bathroom floors, and offensive odors. On another inpatient unit, we found two patient rooms that were dirty after undergoing a terminal cleaning.

Infection Prevention. The JC requires that facilities store equipment properly to reduce the risk of infection. On three different inpatient units, we found dirty equipment stored in clean utility rooms.

Patient Privacy. The Health Insurance Portability Accountability Act requires that staff protect personally identifiable health information on computer monitors by using privacy screens or deterrent positioning. On the same day procedure unit, we found computer screens that were displaying patient information and could be viewed by others passing by.

Recommendations

9. We recommended that processes be strengthened to ensure that patient care areas and fall mats are clean.

10. We recommended that processes be strengthened to ensure that clean and dirty equipment are stored separately.

11. We recommended that processes be strengthened to ensure that sensitive patient information displayed on computer screens is secured.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
X	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in PI over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Integrated Ethics. VHA requires that final summary notes for ethics consults pertaining to active clinical cases be entered into the EHR.[9] We reviewed five ethics consults and found that final summary notes for two were not documented in the EHRs.

Recommendation

12. We recommended that processes be strengthened to ensure that final summary notes for ethics consults pertaining to active clinical cases are documented in the EHRs.

[9] VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
X	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to confirm results with a repeat test, initiate appropriate treatment, and notify the clinician. The employee must then document these actions in the EHR. For 2 of the 10 patients who had critical test results, there was no documented evidence of a repeat test in the EHR.

Equipment Cleaning and Maintenance. VHA requires that the facility follow manufacturers' recommendations for cleaning and maintenance of equipment.[10] In two patient care areas, we found multiple dirty glucometers. In addition, another glucometer appeared to have been repaired with medical tape.

[10] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008.

Recommendations

13. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

14. We recommended that processes be strengthened to ensure that glucometers are cleaned and maintained in accordance with the manufacturer's recommendations.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 24 HF patients' EHRs and relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Discharge Medications. The JC's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In six EHRs, medications ordered at discharge did not match those listed on patient discharge instructions.

Recommendation

15. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[11] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[11] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 10 EHRs, and 66 training/competency records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 19 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (4E) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes C and D, pages 22–29, for the full text of the Directors' comments. We consider Recommendation 11 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[12]		
Type of Organization	Teaching hospital that provides primary and tertiary services	
Complexity Level	2	
VISN	4	
Community Based Outpatient Clinics	Allentown, PA Sayre, PA Williamsport, PA Tobyhanna, PA Berwick, PA Bangor, PA	
Veteran Population in Catchment Area	164,532 (FY 2012)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	68	
• **CLC/Nursing Home Care Unit**	105	
• **Other**	N/A	
Medical School Affiliation(s)	The Commonwealth Medical College	
• **Number of Residents**	5 residents; 2 fellows	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$214.7	$227.0
• **Medical Care Expenditures**	$105.3	$227.0
Total Medical Care Full-Time Employee Equivalents	1,110.0	1,107.1
Workload:		
• **Number of Station Level Unique Patients**	34,402	40,868
• **Inpatient Days of Care:**		
o **Acute Care**	8,148	17,880
o **CLC/Nursing Home Care Unit**	17,611	31,621
Hospital Discharges	1,793	3,613
Total Average Daily Census (including all bed types)	140.7	135.6
Cumulative Occupancy Rate (in percent)	79.5	76.6
Outpatient Visits	192,919	378,967

[12] All data provided by facility management.

VHA Satisfaction Surveys

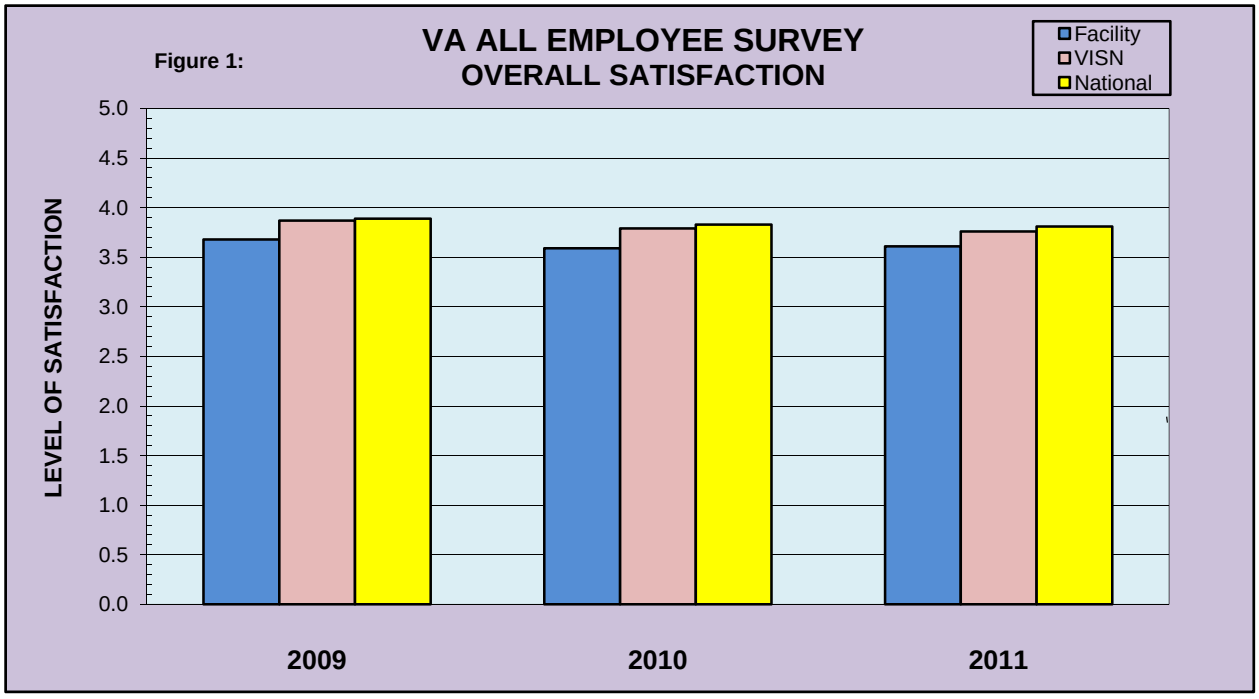
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 2011 and quarter 1 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011		FY 2011			FY 2012
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1
Facility	57.7	64.0	54.1	61.8	61.1	59.8
VISN	63.6	67.4	59.2	61.1	61.6	59.5
VHA	63.9	64.1	55.3	54.2	54.5	55.0

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.[13] 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.[14]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.2	11.6	14.9	20.4	26.3	20.5
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[13] 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 HF 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.

[14] 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: October 12, 2012

From: Director, VISN 4 (10N4)

Subject: **CAP Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Director, Management Review Service (VHA 10AR MRS)

I have reviewed the draft report of the Wilkes-Barre VA Medical Center. I concur with the findings and the facilities response.

MICHAEL E. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 10, 2012

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

Subject: **CAP Review of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Director, VISN 4 (10N4)

The Wilkes-Barre VA Medical Center would like to thank the Office of Inspector General for assisting us in providing quality care to Veterans. We will use the recommendations provided to us during the CAP inspection to improve our processes and become a better healthcare organization. We appreciate all the positive comments as well. Please direct any questions regarding this report to Donna Youngblood, Interim Quality Manager.

Margaret B. Caplan

Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: October 31, 2012

A new CRC screening policy has been written and will be published regarding the guidelines for informing patients after CRC screening and testing. Electronic letters are now generated in the Primary Care administrative office and are mailed daily to all patients with normal and abnormal test results within the required timeframe. Primary Care physicians were trained on this new process electronically via email on June 25, 2012 and again on July 3, 2012. Additional training was also provided in person during a staff meeting on July 18, 2012. Monitoring of service compliance is done weekly via random record reviews.

Recommendation 2. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: August 20, 2012 COMPLETED

The Primary Care/Gastroenterology clinic service agreement revised to ensure that FOBT+ patients have their diagnostic procedure completed within 60 days. A monitor has been started to ensure compliance with this agreement and VHA Directive.

Recommendation 3. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: October 31, 2012

A new CRC screening policy has been written and will be published regarding the guidelines for informing patients after CRC screening and testing. Physicians have been verbally communicating the results to the patients following their procedure as well

as writing the procedure findings on the discharge instructions with any follow-up recommendations (normal cases). Patients with any abnormal findings are informed verbally with also a letter sent to their residence. Any verbal notifications of abnormal results are documented in the patient's electronic medical record. All patients who had a specimen sent for biopsy during their procedure will have a letter sent to their residence. GI staff and the surgeons have been educated about the new process. Each provider was trained on these requirements on one to one basis by GI Physician Assistant (PA) (trained by Chief, Medicine). The GI PA is also reviewing patient records every week to monitor the compliance of each provider. She collects this data and reports to Medical Service sub PI committee thus ultimately going to PI Steering Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: October 31, 2012

A new CRC screening policy has been written and will be published regarding the guidelines for informing patients after CRC screening and testing. Physicians have been verbally communicating the results to the patients following their procedure as well as writing the procedure findings on the discharge instructions with any follow-up recommendations (normal cases). Patients with any abnormal findings are informed verbally with also a letter sent to their residence. All patients who had a specimen sent for biopsy during their procedure will have a letter sent to their residence. GI staff and the surgeons have been educated about the new process.

Recommendation 5. We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within 7 days of discharge and that compliance be monitored.

Concur

Target date for completion: August 20, 2012 with on-going monitoring

No show/cancellation reports are reviewed daily by behavioral health staff with consistent monitoring that patients receive follow-up within 7 days of discharge. WBVAMC's goal is to meet or exceed the national benchmark of 75%.

Recommendation 6. We recommended that the facility offer MH services at least one evening per week.

Concur

Target date for completion: December 31, 2012

Extended clinic hours will be implemented with the hiring of additional clinical staff currently being recruited actively for this purpose.

Recommendation 7. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

Concur

Target date for completion: August 20, 2012 with on-going monitoring

No show/cancellation reports are reviewed daily by behavioral health staff with consistent monitoring to ensure that there are attempts made to follow up with patient's who fail to keep appointments and that these attempts are documented in the patient's medical record.

Recommendation 8. We recommended that processes be strengthened to ensure that treatment plans are provided to polytrauma outpatients and/or their families.

Concur

Target date for completion: August 20, 2012 with on-going monitoring

Treatment plans are documented on the TBI/Polytrauma Rehabilitation/Reintegration Plan of Care template. Any follow up with the polytrauma care team is also documented on the TBI/Polytrauma Rehabilitation/Reintegration Plan of Care template as "interim" or "discharge." Staff will be documenting on the TBI/Polytrauma InterD template that the plan of care has been reviewed with the Veteran and/or their family. The case manager will also be calling the Veteran to review the plan of care and document in this interaction in the patient's medical record.

Recommendation 9. We recommended that processes be strengthened to ensure that patient care areas and fall mats are clean.

Concur

Target date for completion: June 28, 2012 (Cleaning), April 2013 (Project)

All patient care areas including fall mats are cleaned daily. A NRM project has been initiated in order to update several areas of the Community Living Center (CLC) where the deficiencies were identified. This project was obligated September 2012 and has a tentative completion date of April 2013.

Recommendation 10. We recommended that processes be strengthened to ensure that clean and dirty equipment are stored separately.

Concur

Target date for completion: October 31, 2012

Nurse Managers will check the storage rooms on daily rounds for verification of proper storage and will also be listed on the monthly nurse manager EOC checklist. WBVAMC will also have an education blitz for all employees on the proper storage of equipment (clean vs. dirty).

Recommendation 11. We recommended that processes be strengthened to ensure that sensitive patient information displayed on computer screens is secured.

Concur

Target date for completion: October 5, 2012 COMPLETED

Privacy screens have been installed on all computers in the Short Procedure area.

Recommendation 12. We recommended that processes be strengthened to ensure that final summary notes for ethics consults pertaining to active clinical cases are documented in the EHRs.

Concur

Target date for completion: August 31, 2012 COMPLETED

The Integrated Ethic (IE) Program Officer receives a message by the Ethic Consultation Team when an Ethics Consult is placed. Evaluation notification is an automatic notification sent from ECWEB software notifying that Ethic Consult is ready for evaluation. As soon as notification of an Ethic Consult is ready for evaluation, the IE Program Officer will go into the Electronic Medical Record to ensure there is an Ethic Note entered. Per WBVAMC Medical Center Policy, Integrated Ethic Program, 00-10-189, ethic consultations will be entered into the ECWEB data base within 15 days of completion.

In FY2013, Ethic Consultation Coordinator will report to the IE Council any non-compliance and this will be documented in the IE Council Minutes. Each Ethic Consultation will have the following tracking information:

Date of Ethic Request:
Date of Document of Ethic Summary in EMR:
Date of ECWEB completion:
Domain of ECWEB entry:

Example of Notification:

Dear XXXXXXX:

Ethics consultation record number 693-11-XXX is ready to be evaluated.

Recommendation 13. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Concur

Target date for completion: July 1, 2012

The Ancillary Testing Coordinators in Pathology and Laboratory Medicine are monitoring the compliance of both critical value test repeats and direct communication of these critical results with the appropriate provider. A formal Quality Assurance Monitor began July 1, 2012 to monitor the compliance with these practices and the documentation of these practices. The Ancillary Testing Coordinators are currently monitoring 100% of all critical test results. Nursing staff and their supervisors are contacted via e-mail immediately with issues of non-compliance. Data will be presented quarterly at the Ancillary Testing Committee and is also presented to PI Steering Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that glucometers are cleaned and maintained in accordance with the manufacturer's recommendations.

Concur

Target date for completion: October 31, 2012

Glucose machines are listed as non-critical items on the Reusable Medical Equipment (RME) list. They are cleaned after every use with alcohol–IsoTech. All nursing staff will be re-educated to clean the machines after each use and to send machines for repair if they are broken. Each nurse manager will check glucose machines on their daily rounds and will be added to their monthly EOC checklist.

Recommendation 15. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target date for completion: August 20, 2012

Staff were educated during a Medical Staff meeting on July 26, 2012 on the importance of completing medication reconciliation appropriately before discharging patients from their inpatient stay. The medication reconciliation process was reviewed with issues

identified and corrected. Each month five (5) discharged patient names are reviewed for any discrepancies in the med reconciliation note, discharge instructions and discharge summary. All data is reported to the sub PI Committee and then ultimately to the PI Steering Committee for review.

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