Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-04240-60

Combined Assessment Program Review of the White River Junction VA Medical Center White River Junction, Vermont

February 6, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CEB	Clinical Executive Board
EHR	electronic health record
EOC	environment of care
facility	White River Junction VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of December 2, 2013.

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

- Environment of Care
- Coordination of Care

The facility's reported accomplishments were the No Veteran Dies Alone program and the tele-scheduling process for the Sensory/Physical Rehabilitation Service.

Recommendations: We made recommendations in the following four activities:

Quality Management: Consistently complete actions from peer reviews, and report them to the Peer Review Committee. Consistently report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Clinical Executive Board. Revise the local observation bed policy to include all required elements. Ensure the Operative and Invasive Procedure Committee meets monthly and includes the Chief of Staff as a member. Require Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services to consistently attend meetings.

Medication Management: Conduct and document patient learning assessments.

Nurse Staffing: Complete annual staffing plan reassessments timely. Ensure all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Perform and document a patient skin inspection and risk scale daily and at discharge, and develop interprofessional treatment plans. Accurately document pressure ulcer stages, risk scale scores, and wound improvement or deterioration, including wound characteristics, from the time of admission to the time of discharge. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–23, for the full text of the Directors' comments.) 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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2013 and FY 2014 through October 30, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment*

Program Review of the White River Junction VA Medical Center, White River Junction, Vermont, Report No. 11-02077-282, September 15, 2011).

During this review, we presented crime awareness briefings for 112 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 218 responded. We shared summarized 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

No Veteran Dies Alone – Compassionate Companions

The facility has two hospice suites, which offer home-like, comfortable environments for patients at the end of life. To help ensure that veterans at the end of life die with dignity and never alone, the facility instituted the No Veteran Dies Alone program. The program uses trained volunteers to stay with patients in the hospice suites when no family members or loved ones are available. Volunteers are known as "Compassionate Companions" and receive 20 hours of training, which includes communication skills, what to expect when a patient is dying, and the different stages of grief. The program currently has 24 trained volunteers and has provided 101 hours of volunteer service to patients in the facility's hospice suites. In 2013, the No Veteran Dies Alone program was recognized by the VISN 1 Network with a VA Integrity, Commitment, Advocacy, Respect, and Excellence (I CARE) Award.

Sensory and Physical Rehabilitation Service Tele-Scheduling

A tele-scheduling system was instituted to expedite the process for patients making appointments with the Sensory and Physical Rehabilitation Service. If a patient is at a primary care provider visit, and the provider places a consult to the Sensory and Physical Rehabilitation Service, the patient can immediately proceed to a video monitor located outside the clinic room and contact the Sensory and Physical Rehabilitation Service to set an appointment, ask questions, or get information. This eliminates the need for the patient to go to the physical service location and allows the patient to decide with the scheduler on an appropriate date and time for an appointment. Previously, the elapsed time from when a provider placed a consult to when the patient received an appointment was measured in days. The system has succeeded in reducing the time to an average of 22 minutes.

Results and Recommendations

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 met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • Of the three actions expected to be completed, two were not reported to the PRC.
X	FPPEs for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	Seven profiles reviewed: • Of the seven FPPEs completed, results of two were not reported to the CEB.
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	• The facility's policy did not include how the responsible service and provider are determined and that each observation patient must have a focused goal for the period of observation.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted: • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Operative and Invasive Procedure Committee only met 4 times over the past 10 months. Four months of Operative and Invasive Procedure Committee meeting minutes reviewed: • The Chief of Staff was not a member.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Medicine Service attended only two of five meetings, the clinical representative from Anesthesia Service attended only three of five meetings, and no clinical representative from Surgical Service attended meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the CEB.

3. We recommended that the local observation bed policy be revised to include how the responsible service and provider are determined and that each observation patient must have a focused goal for the period of observation.

4. We recommended that the Operative and Invasive Procedure Committee meet monthly and include the Chief of Staff as a member.

5. We recommended that processes be strengthened to ensure that Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected two medical/surgical, the intensive care, and the non-acute behavioral health inpatient units. We also inspected the emergency department, one primary care clinic, the physical therapy/occupational therapy clinic, and the radiology department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employee training records. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	

NM	Areas Reviewed for Acute MH (continued)	Findings
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• Five patients (15 percent) did not have documented learning assessments.
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

6. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 31 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on two inpatient units (acute medical/surgical and MH).[5]

We reviewed facility and unit-based expert panel documents and 14 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 2 randomly selected units—acute medical/surgical unit 1 West and chronic MH unit Ground East—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Twenty-four months passed between initial implementation and the annual reassessment.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• Three of the eight members of the unit-based expert panels had not completed the required training. • Two of the nine members of the facility expert panel had not completed the required training.
	The 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 VHA or local policy.	

Recommendations

7. We recommended that processes be strengthened to ensure that nursing managers complete annual staffing plan reassessments timely.

8. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 17 EHRs of patients with pressure ulcers (6 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 1 patient with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Five of the applicable 15 EHRs did not contain documentation that skin inspections and risk scales were performed at discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 4 of the applicable 16 EHRs, staff did not consistently document pressure ulcer stages and/or risk scale scores.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Seven of the 17 EHRs did not contain consistent documentation that staff performed daily skin inspections and daily risk scales.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
X	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	• Three of the 17 EHRs contained no documentation that interprofessional treatment plans were developed.
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 8 of the 17 patients, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy reviewed: • Seven of the 17 EHRs contained inconsistent documentation of wound characteristics and/or whether the wound had improved or deteriorated from the time of admission to the time of discharge.

Recommendations

9. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale daily and at discharge and develop interprofessional treatment plans and that compliance be monitored.

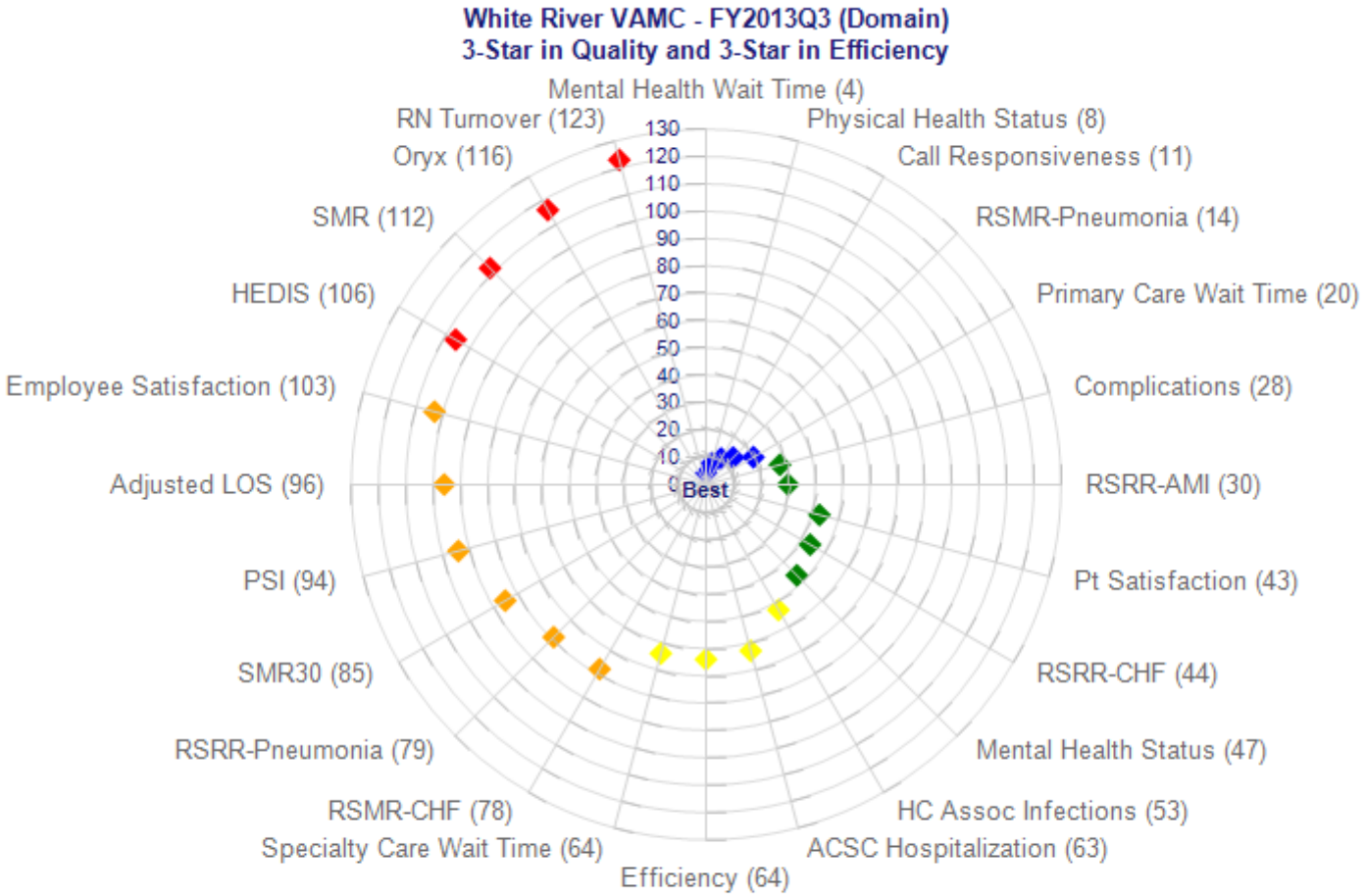
10. We recommended that processes be strengthened to ensure that acute care staff accurately document pressure ulcer stages, risk scale scores, and wound improvement or deterioration, including wound characteristics, from the time of admission to the time of discharge.

11. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Facility Profile (White River Junction/405) FY 2014 through December 2013[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$168.1
Number of:	
• **Unique Patients**	15,804
• **Outpatient Visits**	61,784
• **Unique Employees**[b]	800
Type and Number of Operating Beds (November 2013):	
• **Hospital**	60
• **Community Living Center**	N/A
• **MH**	14
Average Daily Census (November 2013):	
• **Hospital**	36
• **Community Living Center**	N/A
• **MH**	12
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Bennington/405GA Brattleboro/405GC Colchester/405HA St. Johnsbury-Littleton/405HC Keene/405HE Rutland/405HF
VISN Number	1

[a] All data is for FY 2014 through December 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

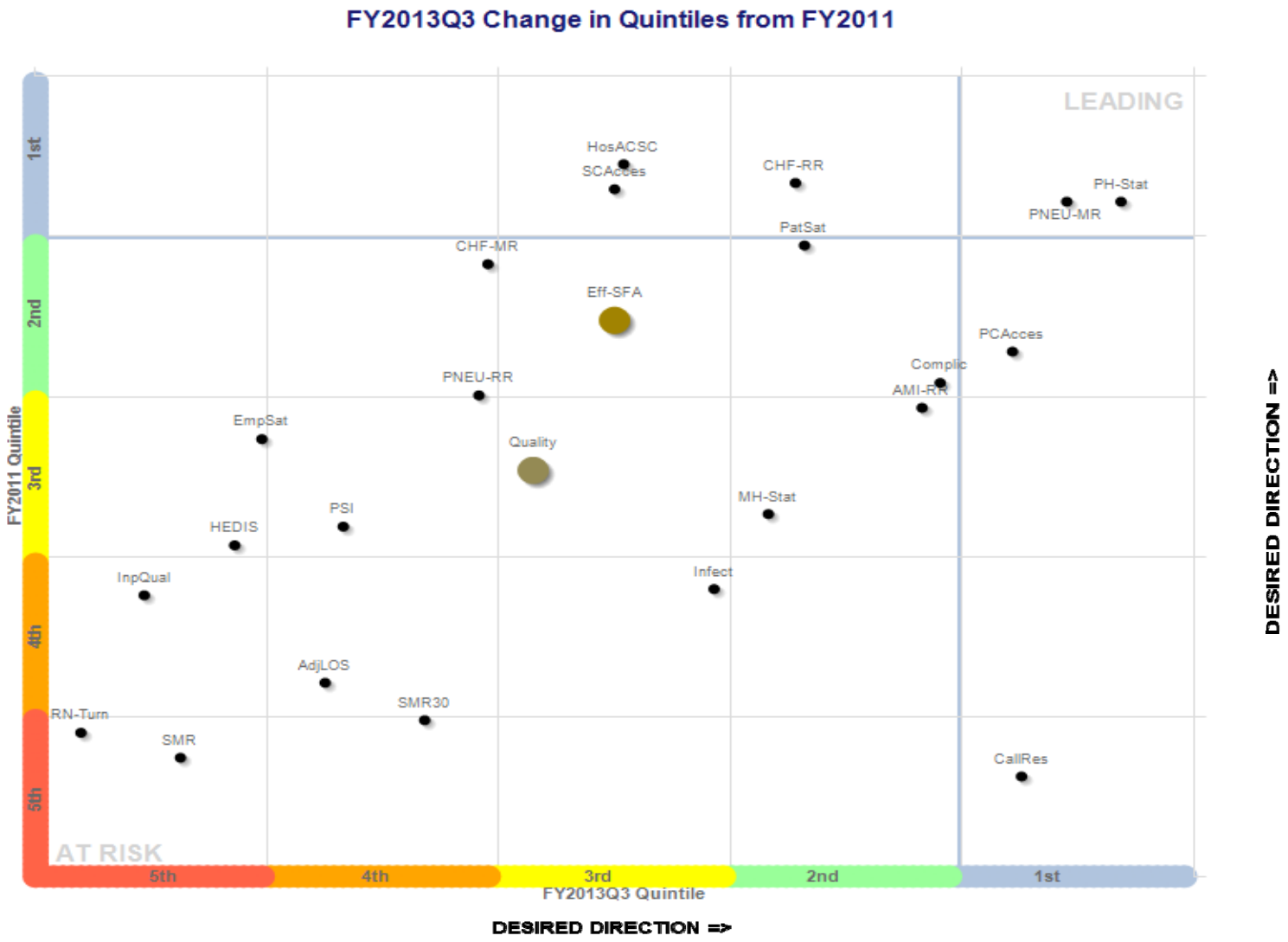
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2014

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I have reviewed and concur with the action plans regarding the Combined Assessment Program Review, White River Junction Medical Center, White River Junction, VT.

Sincerely,

(original signed by:)
Michael Mayo-Smith, MD, MPH
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2014

From: Director, White River Junction VA Medical Center (405/00)

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

To: Director, VA New England Healthcare System (10N1)

I have reviewed and concur with the action plans regarding the Combined Assessment Program Review, VA Medical Center, White River Junction, VT.

(original signed by:)
Deborah Amdur
Medical Center 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 actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: January 2, 2014

Facility response: Effective January 2014, the process for documenting minutes of the Peer Review Committee includes identified action, action owner, and expected action completion date. In addition, action items are tracked each meeting with actual closure date documented in the respective meeting minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPE results for newly hired licensed independent practitioners are consistently reported to the CEB.

Concur

Target date for completion: January 24, 2014

Facility response: Effective January 2014, provider FPPE are tracked by the facility Medical Staff Coordinator on a spreadsheet which is reviewed by the Professional Standards Board at each meeting. The Medical Staff tracking document is used by the Chairperson of the CEB to ensure timely communication to CEB and documentation in CEB minutes.

Recommendation 3. We recommended that the local observation bed policy be revised to include how the responsible service and provider are determined and that each observation patient must have a focused goal for the period of observation.

Concur

Target date for completion: February 1, 2014

Facility response: The local facility policy on Observation Level of Care will be revised to require identification of responsible service and provider, and to require that all patients admitted to Observation level of care have a documented focused goal for the duration of the observation admission.

Recommendation 4. We recommended that the Operative and Invasive Procedure Committee meet monthly and include the Chief of Staff as a member.

Concur

Target date for completion: February 10, 2014

Facility response: The facility will ensure that the Operative and Invasive Procedure Committee will meet monthly. The Chief of Staff will be a participating member.

Recommendation 5. We recommended that processes be strengthened to ensure that Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: February 1, 2014

Facility response: The facility Chief of Staff will communicate requirements for medical staff participation in the Medical Staff Monitoring Committees, including Blood Usage Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that patient learning assessments are conducted and documented and that compliance be monitored.

Concur

Target date for completion: April 1, 2014

Facility response: The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to the Associate Chief Nursing Services, Acute Care Programs and Chief, Education and Knowledge Management Officer. WRJ will assure inpatient learning assessments are completed and documented within 24 hours of admission per local policy. Compliance with documentation is monitored by unit nurse managers with outliers being identified and responsible parties individually reeducated in the process. Oversight of monitoring will be provided by the Nursing Quality & Performance Council.

Recommendation 7. We recommended that processes be strengthened to ensure that nursing managers complete annual staffing plan reassessments timely.

Concur

Target date for completion: April 1, 2014

Facility response: The fiscal year 2013 re-evaluation of staffing methodology will be completed no later than April 1, 2014, for medical-surgical units, in-patient mental health

unit and intensive care unit. In subsequent years, the re-evaluation will be conducted during the first quarter of the subsequent fiscal year.

Recommendation 8. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: February 1, 2014

Facility response: All staff assigned to the unit-based and facility-based expert panel for staffing methodology will complete required training per VHA Directive 2010-034, no later than February 1, 2014. Completion of this training will be tracked and verified by the Associate Chief Nursing Services, Acute Care Programs, prior to the re-evaluation of staffing methodology.

Recommendation 9. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale daily and at discharge and develop interprofessional treatment plans and that compliance be monitored.

Concur

Target date for completion: January 21, 2014

Facility response: The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to Nursing Leadership and by an electronic Clinical Bulletin – Pressure Ulcer Prevention and Management, to all RNs and LPNs. As of January 21, 2014, nurse managers have instructed all appropriate staff who provide direct care in the in-patient setting that skin inspections and risk assessments will be completed on admission, daily, and prior to discharge, according to local policy. Interprofessional treatment plans are completed by staff conducting the assessment, with the certified wound and ostomy nurse (CWON) developing plans for patients with wound care consults. Oversight of monitoring will be provided by the facility Nursing Quality and Performance Council.

Recommendation 10. We recommended that processes be strengthened to ensure that acute care staff accurately document pressure ulcer stages, risk scale scores, and wound improvement or deterioration, including wound characteristics, from the time of admission to the time of discharge.

Concur

Target date for completion: April 1, 2014

Facility response: The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to Nursing

Leadership and by an electronic Clinical Bulletin – Pressure Ulcer Prevention and Management, to all RNs and LPNs. As of January 21, 2014, nurse managers have instructed all appropriate staff who provide direct care in the in-patient setting that annual training on the Prevention and Management of Pressure Ulcers is now mandatory. Simulation training will be provided by the certified wound ostomy nurse, and will include assessment of pressure ulcer stages, risk scale scores and wound improvement or deterioration, including wound characteristics. Documentation requirements per local policy will also be reviewed during this training. Nursing staff will attend pressure ulcer training at nursing skills days (2014 session scheduled for February 5, 12 and 19). Compliance with training is monitored by unit nurse managers with appropriate personnel actions taken for staff not completing. In addition, the facility wound ostomy nurse regularly conducts medical record quality assurance (QA) reviews for compliance with facility standards for assessment and intervention as well as inter-rater reliability. Reports from VANOD (VA Nursing Outcomes Database) identifying patients with missing assessments, Braden scores less than 12 and wound care consults each prompt a QA review by the wound ostomy nurse. Oversight of monitoring will be provided by the facility Nursing Quality and Performance Council.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: April 1, 2014

Facility response: The Associate Director of Nursing & Patient Care Services (ADNPCS) directed action on this recommendation by direct communication to Nursing Leadership and by an electronic Clinical Bulletin – Pressure Ulcer Prevention and Management, to all RNs and LPNs. As of January 21, 2014, nurse managers have instructed all appropriate staff who provide direct care in the in-patient setting that pressure ulcer education will be provided and documented for patients at risk for and with pressure ulcers (and/or their caregivers) according to local policy. Compliance with documentation is monitored by unit nurse managers with outliers being identified and responsible parties individually reeducated in the process. Oversight of monitoring will be provided by the facility Nursing Quality and Performance Council. In addition, a template progress note which will include a standardized format to document interventions completed and education provided will be used for documentation in CPRS.

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Endnotes

[1] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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[3] References used for this topic included:
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[4] References used for this topic included:
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- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
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