Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-04243-151

Combined Assessment Program Review of the Wilmington VA Medical Center Wilmington, Delaware

May 20, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Wilmington VA Medical Center
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

Table of Contents

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 9, 2013.

Review Results: The review covered seven activities. The facility's reported accomplishments were using a mobile outreach primary care clinic and implementing a Safe Day Call Program.

Recommendations: We made recommendations in all seven of the following activities:

Quality Management: Establish a policy for scanning health records.

Environment of Care: Provide an emergency eyewash station in the dialysis patient care area, and lock the dialysis unit's chemical storage room when unattended. Repair the clinical laboratory urinalysis section's ceiling leak. Replace ceiling tiles in the clinical laboratory urinalysis section and blood bank and in the ambulatory surgery medication room. Establish a policy addressing radiation equipment inspection, testing, and maintenance and fluoroscopy quality control. Ensure designated x-ray and fluoroscopy employees have radiation exposure monitoring completed annually. Post signs in the radiology waiting and procedure rooms asking female patients to notify staff if they may be pregnant.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers. Provide medication lists to patients/caregivers at discharge.

Coordination of Care: Provide patients/caregivers with discharge instructions.

Nurse Staffing: Monitor the staffing methodology that was implemented in August 2013. Reassess the target nursing hours per patient day for unit 4 East to more accurately plan for staffing and evaluate the actual staffing provided.

Pressure Ulcer Prevention and Management: Establish an interprofessional pressure ulcer committee. Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Provide and document recommended pressure ulcer interventions and pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Train designated employees on how to administer the pressure ulcer risk scale and accurately document findings. Ensure that patient care areas are clean, that clean and dirty items are stored separately, and that medications are secured at all times.

Community Living Center Resident Independence and Dignity: Document resident progress towards restorative nursing goals, modify restorative nursing interventions as

needed, and document the modifications. Ensure employees who perform restorative nursing services receive training on and competency assessment for resident transfers. Require that staff do not provide medical treatments to residents during meals in the common dining area.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–29, for the full text of the Directors' comments.) We consider recommendations 6, 7, 12, and 13 closed. We will follow up on the planned actions for the open recommendations 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 seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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 2012, FY 2013, and FY 2014 through December 8, 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 Wilmington VA Medical Center, Wilmington, Delaware,* Report No.11-00024-152, April 27, 2011).

During this review, we presented crime awareness briefings for 242 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 147 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

Mobile Outreach Primary Care Clinic

The facility initiated the mobile outreach primary care clinic to improve access to primary care, social services, and behavioral health for veterans who are homeless or reside in rural areas. The mobile clinic has a primary care provider, ancillary nursing staff, and a social worker who provide services to veterans in southern New Jersey and in southern Delaware at the Home of the Brave, a transitional living center for homeless veterans.

Safe Day Call Program

The Safe Day Call Program provides all staff members and supervisors with a tool to actively promote a culture of safety. Staff can anonymously call in and report patient safety risks, actual events, and near miss situations in a timely fashion without risk of blame. Every weekday, a call is held that facilitates communication, safety education, and problem solving across all facility units and services. Action items to resolve identified risks and issues are immediately assigned to staff to ensure follow-up on problems. This initiative presents an opportunity for collaboration between services, departments, and employees. The goals are patient-centered care and patient safety to help reduce risk of harm to patients, families, caregivers, and staff.

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 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
	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.	
	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.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	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
	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.	
	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.	
	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.	
	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.	
X	The policy for scanning non-VA care documents met selected requirements.	• The facility lacked a scanning policy.

NM	Areas Reviewed (continued)	Findings
	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.	
	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.	

Recommendation

1. We recommended that the facility establish a policy for scanning health records and that compliance with the newly established policy be monitored.

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 the medicine, intensive care, CLC, dialysis, chemotherapy, and ambulatory surgery units and the emergency, laboratory, and radiology departments. 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. 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 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.	
X	Environmental safety requirements were met.	• The dialysis unit patient care area did not have an emergency eyewash station. • The dialysis unit's chemical storage room was unlocked and unattended.
X	Infection prevention requirements were met.	• In the clinical laboratory urinalysis section, there were missing ceiling tiles and water leaking from the ceiling into a trash can on a chair next to instruments used for analysis. • Ceiling tiles were missing in the ambulatory surgery medication room and in the laboratory blood bank.
	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.	

NM	Areas Reviewed for Radiology	Findings
	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.	
X	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	• The facility did not have a policy addressing the frequency of equipment inspection, testing, or maintenance.
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
X	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.	• The facility did not have a policy addressing quality control for fluoroscopy equipment.
X	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.	• Two of the x-ray and/or fluoroscopy employees did not have radiation exposure monitoring completed during the past 12 months.
X	Environmental safety requirements in x-ray and fluoroscopy were met.	• Signs were not posted in waiting rooms asking female patients to notify staff if they may be pregnant, and only one procedure room had such a sign.
	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.	

NM	Areas Reviewed for Acute MH (continued)	Findings
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.	
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.	

Recommendations

2. We recommended that the dialysis patient care area have an emergency eyewash station.

3. We recommended that processes be strengthened to ensure that the dialysis unit's chemical storage room is locked when unattended and that compliance be monitored.

4. We recommended that the clinical laboratory urinalysis section ceiling leak be repaired and that ceiling tiles in the clinical laboratory urinalysis section and blood bank and in the ambulatory surgery medication room be replaced.

5. We recommended that the facility establish a policy addressing radiation equipment inspection, testing, and maintenance and fluoroscopy quality control and that compliance with the newly established policy be monitored.

6. We recommended that processes be strengthened to ensure that designated x-ray and fluoroscopy employees have radiation exposure monitoring completed annually and that compliance be monitored.

7. We recommended that signs be posted in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant.

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 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For the 25 patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	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.	
X	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	• None of the 33 EHRs reflected that patients/caregivers were provided medication lists at discharge.
	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.	

Recommendations

8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that patients/caregivers are provided medication lists at discharge 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 19 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. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
X	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	• None of the 19 EHRs contained documented evidence that patients and/or caregivers were provided with discharge instructions.
	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.	

Recommendations

10. We recommended that processes be strengthened to ensure that patients/caregivers are provided with discharge instructions and that compliance be monitored.

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 long-term care).[5]

We reviewed facility and unit-based expert panel documents and 27 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 4 East and the CLC unit 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.	• Initial implementation was not completed until October 2013.
	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.	
	Members of the expert panels completed the required training.	
X	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	• Unit 4 East's average actual nursing hours per patient day were statistically significantly below the target.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

11. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2013.

12. We recommended that nurse managers reassess the target nursing hours per patient day for unit 4 East to more accurately plan for staffing and evaluate the actual staffing provided.

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, 9 EHRs of patients with pressure ulcers (5 patients with hospital-acquired pressure ulcers, 1 patient with community-acquired pressure ulcers, and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected two patient rooms. 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.	
X	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	• The facility did not have an interprofessional pressure ulcer committee.
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In seven of the nine EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	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.	• Seven of the nine EHRs did not contain evidence that the recommended interventions were provided.
	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 five of the applicable six patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
X	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.	Facility pressure ulcer staff education requirements reviewed: • Five employee training records did not contain evidence of how to administer the pressure ulcer risk scale, and six records did not contain evidence of how to accurately document findings.
X	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	We found deficiencies in one patient room as follows: • There were dirty towels and used ostomy bags on the floor beside the bed. • On the table, there were contaminated forceps and scissors with clean dressing supplies and an unsecured topical medication.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that the facility establish an interprofessional pressure ulcer committee.

14. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that acute care staff provide and document recommended pressure ulcer interventions and that compliance be monitored.

16. 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.

17. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale and how to accurately document findings and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that patient care areas are clean, that clean and dirty items are stored separately, and that medications are secured at all times and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 20 EHRs of residents (10 residents receiving restorative nursing services and 10 residents not receiving restorative nursing services but candidates for services). We also observed four residents during two meal periods, reviewed nine employee training/competency records and other relevant documents, and conversed with key employees. 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 offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• None of the applicable 10 EHRs contained evidence that facility staff documented resident progress towards restorative nursing goals. • In 5 of the applicable 10 paper copy care plans, there was no evidence that facility staff documented that interventions were modified to promote the residents' accomplishment of goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Five employee training/competency records did not contain evidence of completed training and competency assessment for resident transfers.
	The facility complied with any additional elements required by VHA or local policy.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
X	Required activities were performed during resident meal periods.	• Staff provided resident insulin shots in the dining room as meals were served.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

19. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications and that compliance be monitored.

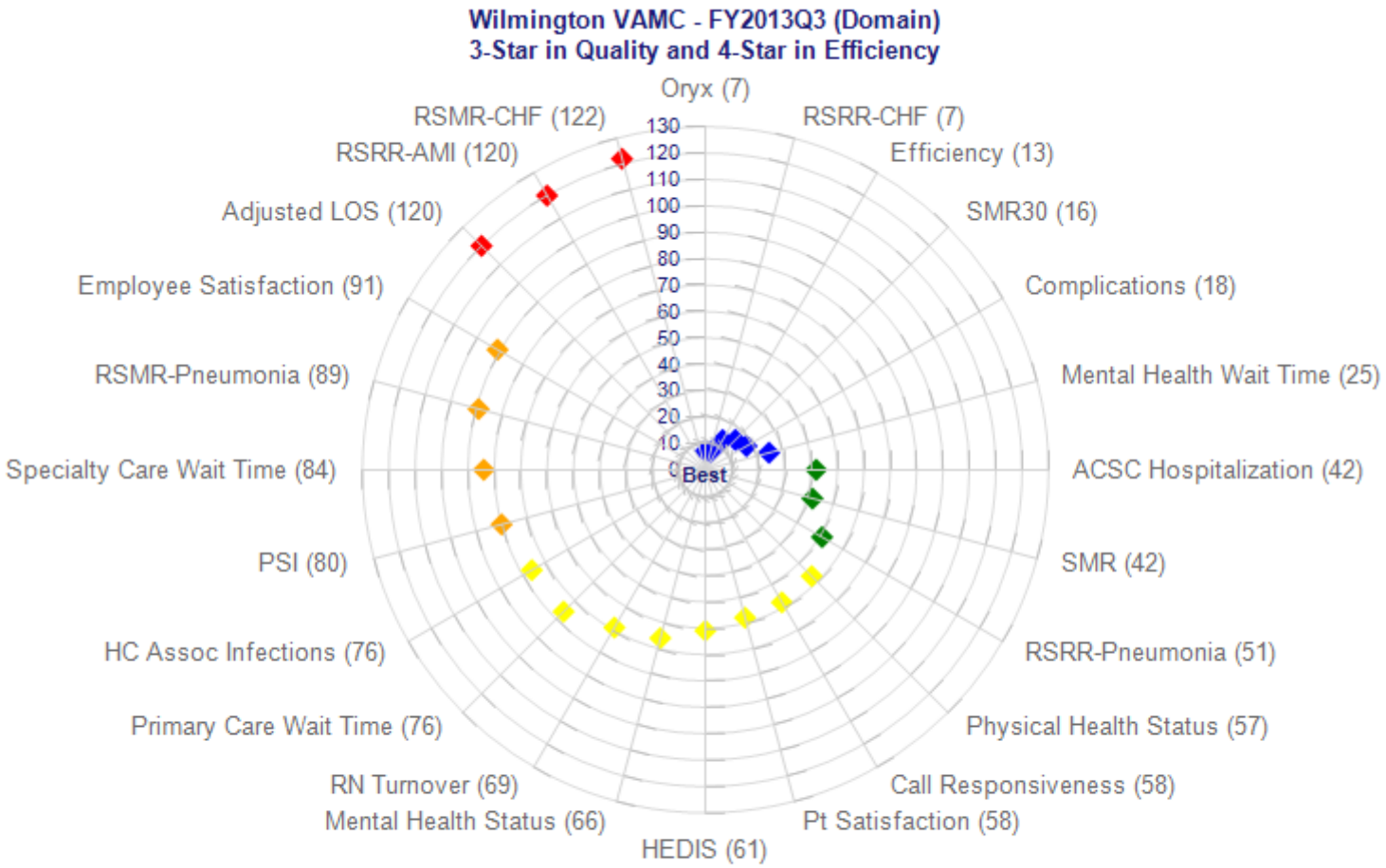
20. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for resident transfers.

21. We recommended that processes be strengthened to ensure that staff do not provide medical treatment to residents during meals in the common dining area.

Facility Profile (Wilmington/460) FY 2014 through March 2014[a]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$162.6
Number of:	
• **Unique Patients**	19,558
• **Outpatient Visits**	109,808
• **Unique Employees**[b]	742
Type and Number of Operating Beds (January 2014):	
• **Hospital**	60
• **CLC**	60
• **MH**	NA
Average Daily Census (February 2014):	
• **Hospital**	22
• **CLC**	47
• **MH**	NA
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Sussex County/460GA Kent County/460GC Cape May USCG/460GD Atlantic County/460HE Cumberland County/460HG MOC Wilmington/460HK
VISN Number	4

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

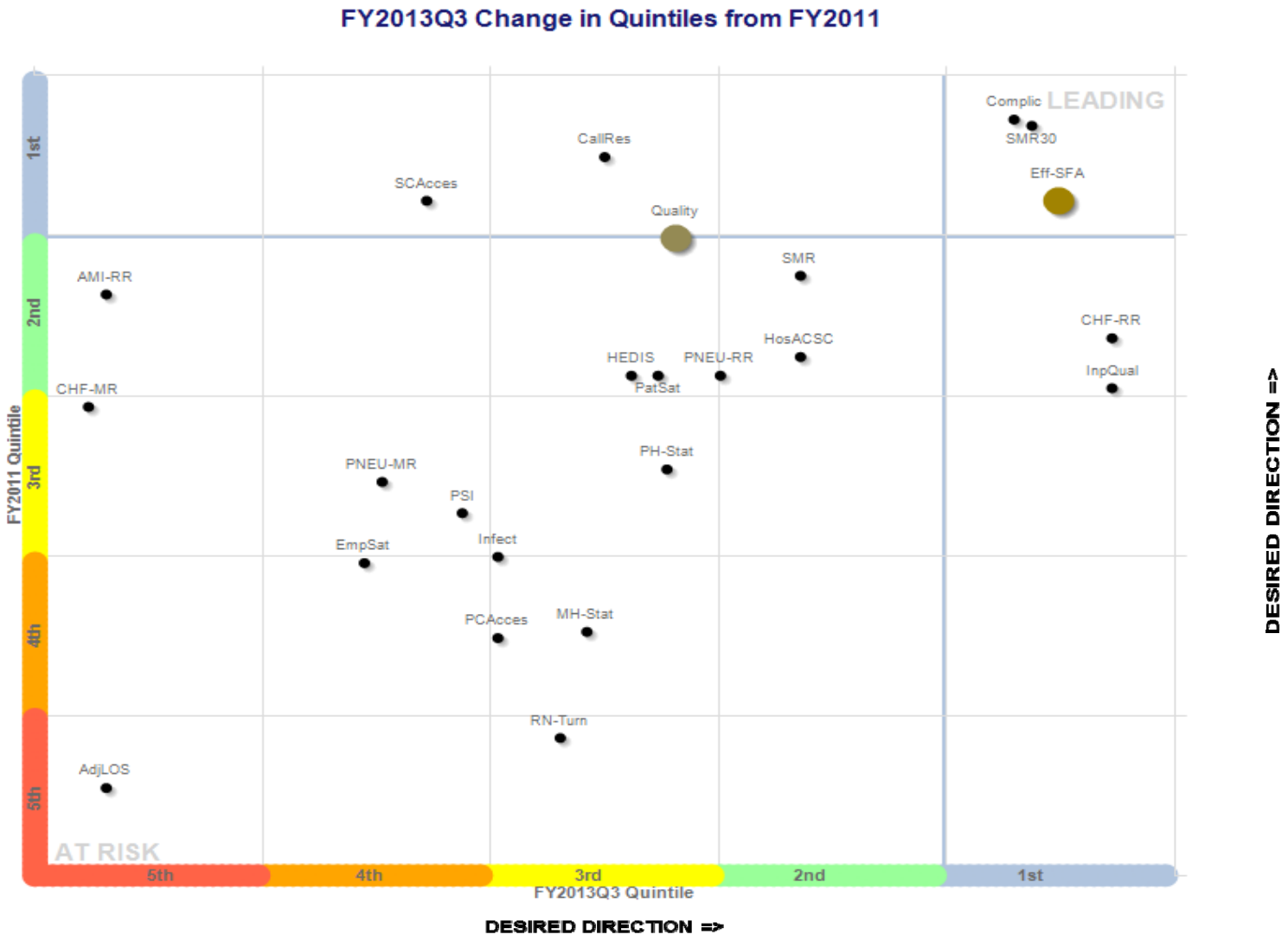
Strategic Analytics for Improvement and Learning (SAIL)[c]



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

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 4, 2014

From: Interim Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. I have reviewed the responses provided by the Wilmington VA Medical Center and I am submitting it to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

(original signed by:)
Gary W. Devansky

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 3/31/2014

From: Director, Wilmington VA Medical Center (460/00)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Wilmington VA Medical Center. We concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care for our Veterans.

(*original signed by:*)
Robin C. Aube-Warren, FACHE
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 the facility establish a policy for scanning health records and that compliance with the newly established policy be monitored.

Concur

Target date for completion: March 25, 2014

Facility response: The facility has completed a policy for scanning and established a monitoring process for compliance. The policy clearly delineates how documents will be reviewed for scanning appropriateness, staff which will do the scanning and how scanning quality will be checked and reported. Education and training of all staff involved in the scanning process has been completed. Compliance with the scanning policy is reported to the Medical Records Council bi-monthly.

Recommendation 2. We recommended that the dialysis patient care area have an emergency eyewash station.

Concur

Target date for completion: May 30, 2014

Facility response: A temporary eyewash station was installed during the OIG survey and a permanent plumbed eyewash station will be installed.

Recommendation 3. We recommended that processes be strengthened to ensure that the dialysis unit's chemical storage room is locked when unattended and that compliance be monitored.

Concur

Target date for completion: March 27, 2014

Facility response: The Nurse Manager makes rounds throughout the day, at a minimum of once daily and checks that dialysis unit's chemical storage room door is shut and locked when not in use. As of February 2014, the Nurse Manager has been documenting door locking compliance. All instances of non-compliance are immediately addressed with the staff. All appropriate staff were re-educated on March 25–27, 2014 on the importance of keeping the chemical storage room locked.

Recommendation 4. We recommended that the clinical laboratory urinalysis section ceiling leak be repaired and that ceiling tiles in the clinical laboratory urinalysis section and blood bank and in the ambulatory surgery medication room be replaced.

Concur

Target date for completion: December 12, 2014

Facility response: The ceiling leaks were due to roof issues. The facility has a construction plan to repair the roof (Project: 460-13-100 Roof Repair & Replacement). Bids are due April 4, 2014. The award should be made no later than the end of June 2014. An interim plan to mitigate leaks was completed during the OIG survey. The facility installed leak diverters to channel water to drains. Ceiling tiles were replaced in the ambulatory surgery area.

Recommendation 5. We recommended that the facility establish a policy addressing radiation equipment inspection, testing, and maintenance and fluoroscopy quality control and that compliance with the newly established policy be monitored.

Concur

Target date for completion: March 26, 2014

Facility response: The facility developed a formal policy addressing radiation equipment inspection, testing, and maintenance, and fluoroscopy quality control. Compliance with the processes was in place at the time of survey and continues.

Recommendation 6. We recommended that processes be strengthened to ensure that designated x-ray and fluoroscopy employees have radiation exposure monitoring completed annually and that compliance be monitored.

Concur

Target date for completion: February 19, 2014

Facility response: All designated x-ray and fluoroscopy employees have received radiation exposure monitoring and will receive monitoring annually. Compliance is tracked in the Radiation Safety Committee.

Recommendation 7. We recommended that signs be posted in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant.

Concur

Target date for completion: February 19, 2014

Facility response: Signs have been posted in waiting and procedure rooms within radiology asking female patients to notify staff if they may be pregnant.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: April 30, 2014

Facility response: The facility will ensure that all clinicians conduct and document medication education to accommodate patients with identified learning barriers (i.e. hearing, vision, physical, cognitive, language). The facility has improved the medication reconciliation process to promote documentation of counseling accomodations using a Patient Education Assment. A communication plan has been developed to educate clinicians about the new template. Compliance will be monitored via chart review and reported to Medical Executive Board.

Recommendation 9. We recommended that processes be strengthened to ensure that patients/caregivers are provided medication lists at discharge and that compliance be monitored.

Concur

Target date for completion: April 30, 2014

Facility response: The nurse at discharge will continue to provide the patient/caregiver a medication list at discharge. The practice of only scanning the wet signature page of discharge instructions has been stopped. Full discharge instructions are posted in the electronic health record via discharge instruction notes that clearly state that a medication list will be provided to the patient or caregiver at discharge. Focus on the process will be strengthened by adding a specific compliance monitor to be completed by the unit nurse educators with results reported to the Nurse Practice Council.

Recommendation 10. We recommended that processes be strengthened to ensure that patients/caregivers are provided with discharge instructions and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility response: Nurses will continue to document on the nurse discharge note that the patient/caregiver received and understood the discharge instructions. Focus on the process will be strengthened by adding a specific compliance monitor to be completed by the unit nurse educators with results reported to the Nurse Practice Council. Any identified improvement opportunities will be addressed by the Nurse Practice Council.

Recommendation 11. We recommended that nursing managers monitor the staffing methodology that was implemented in August 2013.

Concur

Target date for completion: May 30, 2014

Facility response: The facility's nursing leadership met and developed a monitoring system to track each nursing unit's Hours per Patient Day (HPPD). As of January 2014, each Nurse Manager has been monitoring unit HPPD with each unit's expert panel. The quarterly facility expert panel will meet in May, 2014 to assess trends and recommend changes if needed.

Recommendation 12. We recommended that nurse managers reassess the target nursing hours per patient day for unit 4 East to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: January 2, 2014

Facility response: The facility's 4E nurse manager in consultation with the Acute Care Associate Chief Nurse reviewed the unit's acuity and scope and decreased the Nursing Hours per Patient Day (NHPPD) to 8.9. This decrease was made due to the determination to limit cardiac IV treatments to the Intensive Care Unit.

Recommendation 13. We recommended that the facility establish an interprofessional pressure ulcer committee.

Concur

Target date for completion: December 30, 2014

Facility response: The facility's interprofessional Integrated Skin Integrity, Wound and Pressure Ulcer Care Committee provides oversight to the facility's pressure ulcer prevention program. The Pressure Ulcer Work Group aggregates and analyzes data. Discrepancy reports are sent to unit managers designating areas of improvement opportunity.

Recommendation 14. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: May 30, 2014

Facility response: The facility's Pressure Ulcer Work Group developed and implemented an updated note that includes improved documentation of the location, stage, risk score, and date pressure ulcer acquired. All acute care staff members are being in-serviced on the use of the new note; training records will be entered into TMS. Chart audits will be conducted by the members of the Pressure Ulcer Work Group using a standardized audit form to include monitoring for consistent documentation of pressure ulcers, including: stage, location, risk score, and adherence to stated standards.

Recommendation 15. We recommended that processes be strengthened to ensure that acute care staff provide and document recommended pressure ulcer interventions and that compliance be monitored.

Concur

Target date for completion: May 30, 2014

Facility response: The facility's Pressure Ulcer Work Group developed and implemented an updated note that includes accurate documentation of pressure ulcer interventions. All acute care staff members are being in-serviced on the use of the new note; training records will be entered into Training and Management System (TMS). Chart audits will be conducted by the members of the Pressure Ulcer Work Group to include monitoring for consistent documentation of pressure ulcer interventions.

Recommendation 16. 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 25, 2014

Facility response: The facility strengthened pressure ulcer education processes. On admission all acute care patients at risk for pressure ulcers and/or their caregivers will be given an informational folder, to include a handout from Krames on Demand about pressure ulcer prevention. On the 4E med/surg unit documentation and review of information will be noted in the Electronic Health Record (EHR) on the Daily Nursing Assessment. In ICU, documentation and review of information will be noted in the EHR via PICIS, an electronic flow charting system. Staff training on the pressure ulcer education processes is documented in TMS.

Recommendation 17. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale and how to accurately document findings and that compliance be monitored.

Concur

Target date for completion: March 31, 2014

Facility response: The facility strengthened pressure ulcer training processes. Training was provided by unit educators and wound care nurses in October 2013 on the following topics: Skin Assessment/Reassessment Documentation; Pressure Ulcer Staging; Use of Braden Scale, What Do the Numbers Mean; Wound Care Products and Underpads; Wound Management; Skin Integrity and Wound Care in 2014; and Pressure Ulcer Education. Additionally, one-on-one training/demonstration, return demonstration, story boards with samples of wound care products, and small group instruction was completed on the units. Ongoing training provided by the Education Department has the following objectives: the nurse will be able to accurately perform and document a head to toe skin assessment; will be able to identify patients at risk for pressure ulcers; will be able to develop and implement an individualized nursing skin integrity plan of care. Intensive training has been occurring since October 2013 and will continue through March 31, 2014. Quarterly training updates will be completed based on audit results. Documentation of all staff training on pressure ulcers is entered into TMS. Patient charts are being monitored by the nursing unit educators and reported to the Pressure Ulcer Work Group.

Recommendation 18. We recommended that processes be strengthened to ensure that patient care areas are clean, that clean and dirty items are stored separately, and that medications are secured at all times and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: To strengthen our process that ensures patient care areas are clean, Nursing staff, Nurse mangers, Environmental Management service (EMS) staff and EMS leadership now have a bi-weekly meeting to discuss cleanliness of all patient care areas. A checklist was developed for EMS staff to use, and the EMS supervisor now makes rounds, and confers with the charge nurse daily to address any issues, provide them with the assigned EMS mobile phone number, and staff's name. Nurse managers and the EMS chief collaborated to obtain separate trash and linen carts for staff to use and coordinated pickup times of dirty linen and trash with nursing care time so dirty items are not left in patients rooms for any length of time. Compliance is being monitored by the Infection Control Committee. Nurse managers make rounds throughout the day and immediately correct any medication security issues. Environment of Care rounds and Pharmacy rounds also routinely check for medication security issues throughout the facility. Pharmacy performs monthly inspections of all ward stock and documents all elements on the Medication Inspection Form for Wards and Clinics (VA Form 10-0053) to ensure proper storage and maintenance of ward stock and reports quarterly to Pharmacy and Therapeutic Council.

Recommendation 19. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify restorative nursing interventions as needed, and document the modifications and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility response: As of January 2014 restorative assessments are being completed on admission, quarterly, annually, with significant changes, and by consult requests. The assessment contains the resident's functional ability, restorative recommendations, and education. Daily minutes are documented on flow sheets by the caregivers. The flow sheets include participation minutes and tolerance to activity. Weekly overviews are documented in the Weekly LPN Notes. These notes include weekly participation and education. Monthly assessments are documented in the Monthly Nursing Notes. These notes include monthly participation, assessment of goals, and education. Accu-Care contains resident's care plans documented with resident's goals. Tools for performance improvement include, but are not limited to: A weekly Interdisciplinary Team review of all restorative programs and a monthly audit for compliance with documentation requirements is provided to the Community Living Center Nurse Manager.

Recommendation 20. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on and competency assessment for resident transfers.

Concur

Target date for completion: May 1, 2014

Facility response: The facility is developing a standardized competency checklist for restorative nursing services to confirm that all elements of restorative competencies are completed. The checklist will be used to confirm that all employees who perform restorative nursing services have training on and competency assessment for resident transfers. Results will be reported to the Extended Care Council.

Recommendation 21. We recommended that processes be strengthened to ensure that staff do not provide medical treatment to residents during meals in the common dining area.

Concur

Target date for completion: June 15, 2014

Facility response: A separate and private room has been provided adjacent to the dining area for residents desiring to receive any medical treatments such as blood glucose monitoring, insulin injections, or other medications during meal times or in the common

dining area instead of returning to their rooms. Staff have been educated to utilize this room so medical treatments may be provided in a private setting.

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This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
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- VHA Directive 6300, *Records Management*, July 10, 2012.
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- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[2] References used for this topic included:
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- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
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- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding–Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
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- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[6] References used for this topic included:
- 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.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
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