Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02073-57

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

January 6, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Wilkes-Barre VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
QM	quality management
SDS	same day surgery
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 September 15, 2014.

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

- Environment of Care
- Medication Management
- Coordination of Care
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishment was the implementation of the HyGreen® hand hygiene monitoring system.

Recommendations: We made recommendations in the following three activities:

Quality Management: Require the Medical Executive Committee to discuss and document its approval of the use of another facility's providers for teledermatology services. Reassess observation criteria and utilization timely when conversions from observation bed status to acute admissions are over 30 percent. Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure the Surgical Work Group meets monthly and reviews relevant data elements. Review the quality of entries in the electronic health record. Ensure the Transfusion Review Committee members from Medicine, Surgery, and Anesthesia Services consistently attend meetings.

Acute Ischemic Stroke Care: Revise the stroke policy/plan/guideline to address screening for difficulty swallowing, and fully implement the policy/plan/guideline. Complete and document National Institutes of Health stroke scales for each stroke patient. Collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Magnetic Resonance Imaging Safety: Conduct fire emergency drills in magnetic resonance imaging (MRI). Conduct initial patient safety screenings. Complete secondary patient safety screenings immediately prior to MRI. Ensure radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan. Properly use barriers to restrict access to MRI Zone III. Ensure MRI technologists have visual contact at all times with

patients in the magnet room. Regularly test the two-way communication device. Appoint an MRI Safety Committee.

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 20–27, for the full text of the Directors' comments.) We consider recommendations 1, 6, 9, and 10 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
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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 September 18, 2014, 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 Wilkes-Barre VA Medical Center, Wilkes-Barre, Pennsylvania,* Report No. 12-01877-25, November 7, 2012).

During this review, we presented crime awareness briefings for 156 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 263 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 Accomplishment

HyGreen® Hand Hygiene Monitoring System

In 2013, the facility implemented the HyGreen® hand hygiene monitoring system as a tool to determine the effectiveness of the hand hygiene program. The HyGreen® system uses sensors to monitor hand hygiene and alerts the health care worker if hand hygiene was overlooked. The facility installed the system on the medical/surgical inpatient units and the intensive care unit and in the CLC. Providers, nurses, respiratory therapists, radiology technicians, and phlebotomists currently use the badge monitoring mechanism. Infection prevention staff members monitor data from the system and report to the Infection Prevention Committee.

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.[a]

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.	
	The protected peer review process met selected requirements: • The Peer Review Committee 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 Peer Review Committee. • The Peer Review Committee 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.	
X	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.	Twelve months of MEC meeting minutes reviewed: • There was no evidence that the MEC approved the use of another facility's providers for teledermatology services.

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.	Twelve months of observation bed data reviewed: • For July 2013–June 2014, an average of 53 percent of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization during that time.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	• For June 2013–July 2014, there was no data available for continuing stay reviews.
	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. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• Although required to be in place by January 2013, the Surgical Work Group was not initiated until February 2014; therefore, the group met only 6 times over the past 12 months. Six months of Surgical Work Group meeting minutes reviewed: • Additional data elements were not routinely reviewed.
	Critical incidents reporting processes were appropriate.	
X	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.	• There was no evidence that the quality of entries in the EHR was reviewed.
	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 Transfusion Review Committee meeting minutes reviewed: • The clinical representative from Medicine Service attended only 6 of 11 meetings, and the representatives from Surgery and Anesthesia Services attended only 9 of 11 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 the Medical Executive Committee discuss and document its approval of the use of another facility's providers for teledermatology services.

2. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on at least 75 percent of patients in acute beds.

4. We recommended that the Surgical Work Group meet monthly and review relevant data elements.

5. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

6. We recommended that processes be strengthened to ensure that the Transfusion Review Committee members from Medicine, Surgery, 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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected SDS, the PACU, the eye clinic, medical/surgical unit 4 East, the intensive care unit, the emergency department, the 2nd floor unit of the CLC, and the inpatient mental health unit. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 19 employee training records (11 SDS, 2 PACU, and 6 eye clinic). 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 SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	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.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	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.	

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 33 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.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 13 patients who experienced stroke symptoms, and 10 employee training records (4 emergency department and 6 intensive care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, one critical care unit, and one acute inpatient unit. 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's stroke policy/plan/guideline addressed all required items.	• The facility's policy/plan/guideline did not address screening for difficulty swallowing.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twelve EHRs did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
	Clinicians provided printed stroke education to patients upon discharge.	
	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that the facility's stroke policy/plan/guideline be revised to address screening for difficulty swallowing, that the policy/plan/guideline be fully implemented, and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

9. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility 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.[f]

We reviewed 11 EHRs of residents (10 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. 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
	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.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's 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.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 35 employees (30 randomly selected Level 1 ancillary staff and 5 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of the MRI area. 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 completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• Fire emergency drills were not conducted in the MRI area.
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Eleven EHRs (31 percent) did not contain initial patient safety screenings. • Twelve EHRs (34 percent) did not contain completed secondary patient safety screenings.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Eleven of the 23 EHRs with secondary patient safety screening forms did not contain documentation that all identified contraindications were addressed prior to MRI.
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
X	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	• Zone III was not adequately protected to prohibit unauthorized access.
X	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	• An MRI technologist was observed not having visual contact with the patient part of the time that the patient was in the magnet room (Zone IV). • Facility staff did not regularly test the two-way communication device.
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

NM	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy requires that a facility have an MRI Safety Committee • The facility had not appointed an MRI Safety Committee.

Recommendations

10. We recommended that processes be strengthened to ensure that fire emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

14. We recommended that barriers are properly used to restrict access to magnetic resonance imaging Zone III and that compliance be monitored.

15. We recommended that magnetic resonance imaging technologists have visual contact at all times with patients in the magnet room.

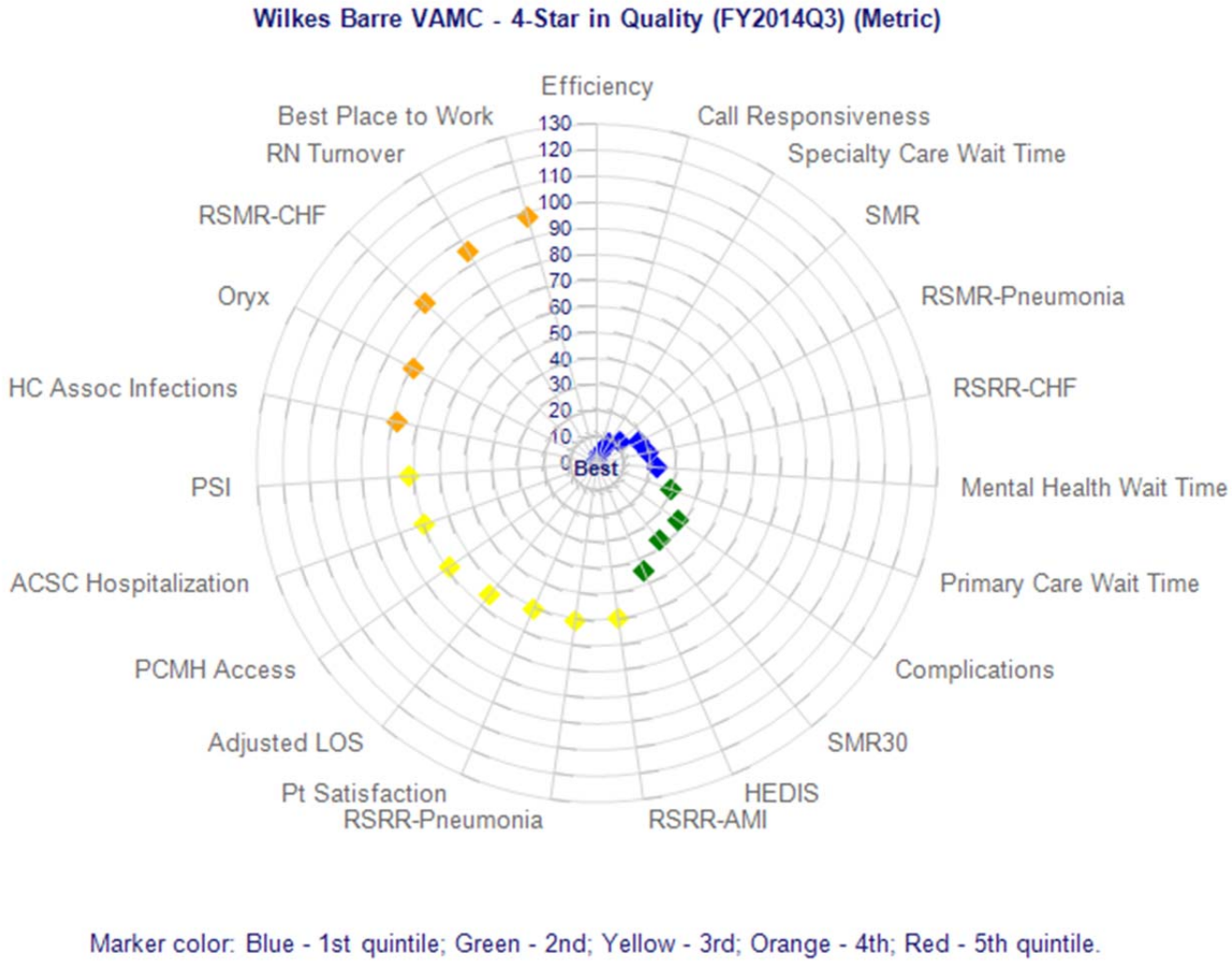
16. We recommended that processes be strengthened to ensure that the two-way communication device is regularly tested and that compliance be monitored.

17. We recommended that a Magnetic Resonance Imaging Safety Committee be appointed.

Facility Profile (Wilkes-Barre/693) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$209
Number of:	
• **Unique Patients**	38,137
• **Outpatient Visits**	350,996
• **Unique Employees**[2]	1,000
Type and Number of Operating Beds (July 2014):	
• **Hospital**	58
• **CLC**	105
• **Mental Health**	10
Average Daily Census (July 2014):	
• **Hospital**	35
• **CLC**	81
• **Mental Health**	9
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Allentown/693B4 Sayre/693GA Williamsport/693GB Tobyhanna/693GC Berwick/693GF Northampton/693GG
VISN Number	4

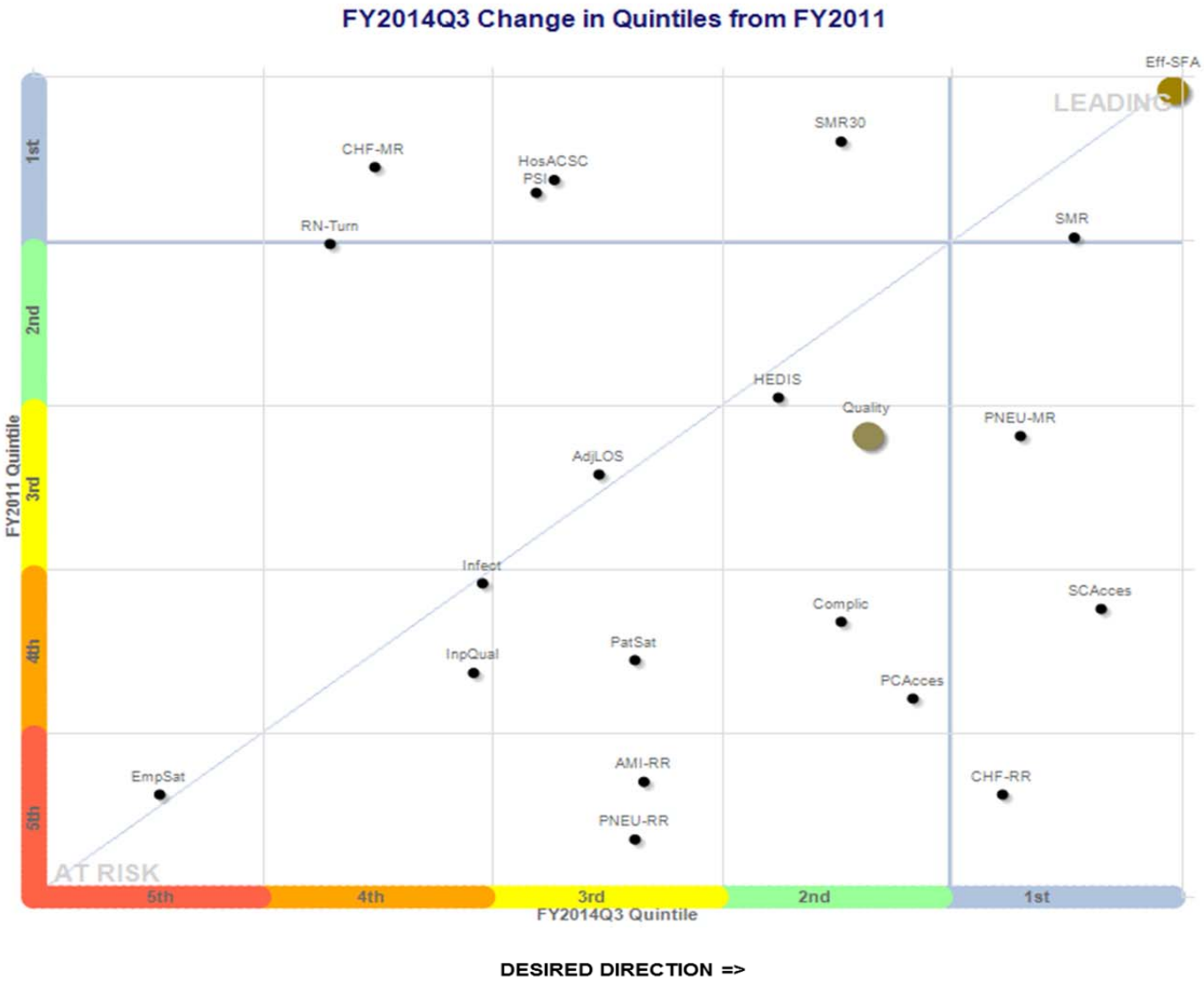
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] 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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 25, 2014

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

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

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

VHA 10AR MRS OIG CAP CBOC Reviews
OIG Follow-Up Staff (53B)

1. I have reviewed the response provided by the Wilkes-Barre VA Medical Center and I am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, Acting VISN 4 Quality Management Officer at 412-822-3294.

(original signed by:)
Gary W. Devansky

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 24, 2014

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

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

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

1. VA Medical Center Wilkes-Barre, PA, (WBVAMC) concurs with the OIG recommendations as outlined in the report.

2. Attached please find WBVAMC response to the recommendations outlined in the OIG report.

Michael D. Adelman, MD

Digitally signed by Adelman, Michael
DN: dc=gov, dc=va, ou=Entities, ou=InternalStaff, cn=Adelman, Michael
Date: 2014.11.25 14:24:33 -05'00'

Michael D. Adelman, M.D.

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 Medical Executive Committee discuss and document its approval of the use of another facility's providers for teledermatology services.

Concur

Target date for completion: 10/9/2014

Facility response: Credentialing and Privileging Committee submitted a request to Medical Executive Committee at the October 9th, 2014 meeting to approve Teledermatology services via telemedicine. This approval will be evidenced by signed Medical Executive Committee meeting minutes that reflect discussion of the request with the appropriate action for approval.

Recommendation 2. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

Concur

Target date for completion: 1/5/2015

Facility response: We had experienced an increase in observations to admission percentages for various reasons, one being the lack of utilization management staff, and the other a lack of education to practitioners to the criteria for observation.

Current VHA Support Service Center data reflects the efforts of an increase in utilization management staffing and a very active Physician Utilization Management Advisor who began being fully utilized July 2014. For July, August, and September Observations discharge to admit is now 34%.

Recommendation 3. We recommended that processes be strengthened to ensure that continuing stay reviews are consistently performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: 1/5/2015

Facility response: The organization was without utilization staff from December 2013 to June 2014. The staffing had been one when the benchmark for staffing at this facility was 2.5. With the increase in staffing to three we have greatly improved our continued stay reviews. Currently, July, August, and September show facility is at 96.7 percent Continue Stay Reviews.

Recommendation 4. We recommended that the Surgical Work Group meet monthly and review relevant data elements.

Concur

Target date for completion: 1/5/2015

Facility response: The Surgical Quality Work Group was initiated in February 2014 and has met monthly with the exception of March 2014, under the direction of the Chief, Surgical Services. Monthly meeting compliance will be monitored. Relevant data elements reviewed.

Recommendation 5. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed.

Concur

Target date for completion: 1/5/2015

Facility response: The Medical Records Committee will require all services to report their service level record reviews for quality of electronic health record entries monthly. E-mail was sent by secretary of Medical Records Committee 10/23/14 on behalf of co-chairs requesting service level record reviews for submission by 11/6/14 for upcoming 11/12/14 Medical Records Committee meeting. Results will be recorded and reflected in the Medical Record Committee minutes.

Recommendation 6. We recommended that processes be strengthened to ensure that the Transfusion Review Committee members from Medicine, Surgery, and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: 12/1/2014

Facility response: An updated recurring meeting appointment was sent to all members on their Microsoft Outlook calendar. Attendance will be recorded in the minutes. A review of required committee members was conducted to consolidate membership. September meeting showed 100 percent attendance.

Recommendation 7. We recommended that the facility's stroke policy/plan/guideline be revised to address screening for difficulty swallowing, that the policy/plan/guideline be fully implemented, and that compliance be monitored.

Concur

Target date for completion: 1/5/2015

Facility response: Treatment of Acute Ischemic Stroke Policy revised to address screening for difficulty swallowing and approved for publication. Algorithm for bedside swallow assessment has been posted in all acute care areas. Associate Chief of Medicine will audit each suspected stroke patient for 100 percent compliance. Results will be forwarded to the Critical Care Committee monthly for 90 days and then quarterly. October to date audit showed that screening for difficulty swallowing was 100 percent.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 1/5/2015

Facility response: National Institutes of Health Stroke Scale is currently in the stroke template in the Electronic Health Record. Education on the use of the template was provided to all Licensed Independent Practitioners. Associate Chief of Medicine will audit each suspected stroke patient for 100 percent compliance. Results will be forwarded to the Critical Care Committee monthly for 90 days and then quarterly. October to date audit showed that National Institutes of Health Stroke Scale documentation was 100 percent.

Recommendation 9. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: 12/1/2014

Facility response: Excel spreadsheet was created for collecting the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. FY13 and FY14 data has been uploaded to IPEC and the Associate Chief of Medicine will continue to update monthly.

Recommendation 10. We recommended that processes be strengthened to ensure that fire emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 10/20/2014

Facility response: Fire emergency drill completed on 10-20-2014 and satisfactory report was sent to Radiation Safety Committee until Magnetic Resonance Imaging Safety Committee is formed. The fire emergency drill will be a line item in minutes for ongoing annual compliance.

Fire drill format changed to signatures at the end. Also, remainder of emergency drills were performed and documented completing Standard 7 (EMERGENCY DRILLS) on the VISN MRI Safety Audit changing that standard to full compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: 3/31/2015

Facility response: MRI technologists and physicians educated that no MRI order will be accepted or scheduled without prescreening completed by physician. A random audit of 50 cases per month will be monitored for 100 percent compliance. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program. Results will be reported to Radiation Safety Committee until Magnetic Resonance Imaging Committee is formed.

Recommendation 12. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 3/31/2015

Facility response: Radiology supervisor educated staff on completing the entire secondary patient safety screening on 9/22/2014. A random audit of 50 cases per month will be monitored for compliance for 100 percent compliance. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program. Results will be reported to Radiation Safety Committee until Magnetic Resonance Imaging Committee is formed.

Recommendation 13. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 3/31/2015

Facility response: Currently, documentation of Magnetic Resonance Imaging contraindications is documented on a hard copy secondary screening form. To provide more detail an electronic secondary screening form is being implemented with a particular area added as a *Technologist Review to any "YES" answers: in the Medical review_____. Action taken_____.*

Hard copy documentation of completion of secondary screening, which includes contraindications and details will be monitored until electronic secondary screening form is implemented. A random audit of 50 cases per month for 100 percent compliance will be performed. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program. Results will be reported to Radiation Safety Committee until Magnetic Resonance Imaging Committee is formed.

Recommendation 14. We recommended that barriers are properly used to restrict access to magnetic resonance imaging Zone III and that compliance be monitored.

Concur

Target date for completion: 3/31/2015

Facility response: A Standard Operating Procedure was created defining physical security and access to Magnetic Resonance Imaging suite. Education was performed for all staff and physicians working in the Magnetic Resonance Imaging suite or surrounding areas on security and access to Magnetic Resonance Imaging suite. The radiology manager will monitor the Magnetic Resonance Imaging suite doors for access/security compliance randomly throughout the day to ensure 100 percent compliance. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program.

Recommendation 15. We recommended that magnetic resonance imaging technologists have visual contact at all times with patients in the magnet room.

Concur

Target date for completion: 1/5/2015

Facility response: Magnetic Resonance Imaging Safety Policy # 115-14-22 Dated March 22, 2014 (8)(a)(7) Patients in the magnet room will be under the direct observation of the technologist at all times.

Technologists were re-educated on 9/19/2014 on policy stipulation requiring visual contact with patient at all times in the magnet room.

All Nuclear Medicine technologists who work in very close proximity to the MRI suite have taken the Magnetic Resonance Imaging Safety Level II training. They will be able to assist monitoring patients in the MRI Suite Zones II, III, and IV at times when there is only one Magnetic Resonance Imaging technologist in the control room with full attention to the patient in the scanner. The magnetic resonance imaging technologists have visual contact at all times with patients in the magnet room. At least twice daily the radiology supervisor will monitor to verify that the magnetic resonance technologist is at their required post and patient is not left unobserved to ensure 100 percent compliance. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program. Results will be reported to Radiation Safety Committee until Magnetic Resonance Imaging Committee is formed.

Recommendation 16. We recommended that processes be strengthened to ensure that the two-way communication device is regularly tested and that compliance be monitored.

Concur

Target date for completion: 1/5/2015

Facility response: A daily startup checklist has been created for Magnetic Resonance Imaging technologists to check the 2-way communication device functionality. This check will occur each morning and the checklist will be monitored for 100 percent compliance. This monitor will be ongoing as a part of Magnetic Resonance Imaging quality assurance program. Results will be compiled monthly and forwarded to the Radiation Safety Committee until the Magnetic Resonance Imaging Committee is formed.

Daily Start Up Magnetic Resonance Imaging Tests/Checks are part of MRI technologists Competencies (pg. 4).

Recommendation 17. We recommended that a Magnetic Resonance Imaging Safety Committee be appointed.

Concur

Target date for completion: 1/5/2015

Facility response: Currently, all Magnetic Resonance Imaging data/information is presented to Radiation Safety Committee. A Magnetic Resonance Imaging Safety Committee is being formed. First meeting is slated for 11/14/2014. This also completes Standard 1 (MRI SAFETY OFFICER AND MRI SAFETY COMMITTEE) on the VISN Magnetic Resonance Imaging Safety Audit changing that standard to full compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Jennifer Christensen, DPM, Team Leader Margie Chapin, RT (R, MR, CT), JD Terri Julian, PhD Alison Loughran, JD, RN Melanie Oppat, MEd, LDN Sonia Whig, MS, LDN Gerard Poto, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Jeff Joppie, BS Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

[a] 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.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] 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, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.