Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-01001-130

Combined Assessment Program Review of the Spokane VA Medical Center Spokane, Washington

May 20, 2009

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Table of Contents

Executive Summary

Introduction

During the week of March 16–19, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Spokane VA Medical Center (SVAMC), Spokane, WA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 153 SVAMC employees. The SVAMC is part of Veterans Integrated Service Network (VISN) 20.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strengths and reported accomplishments:

- Data sharing between Surgery Service and Infection Control Practitioner (ICP).
- Safety procedures for methadone use.
- Environmental achievement award.

We made recommendations in five of the activities reviewed. For these activities, the SVAMC needed to:

- Ensure that physician privileging processes comply with Veterans Health Administration (VHA) requirements.
- Require consistent documentation of discussions regarding QM data analyses and implement actions to address identified problems.
- Ensure that the patient advocate provides detailed patient complaint analyses and presents reports to appropriate venues for discussion and action.
- Establish a process for comprehensive monitoring of medication reconciliation.
- Correct identified environment of care (EOC) deficiencies.
- Ensure that emergency department (ED) nursing staff competencies are completed and current.
- Ensure that physician orders and discharge summaries are consistent.
- Ensure timely documentation of pain medication effectiveness and develop a process to monitor patients in the self-medication program (SMP).

The SVAMC complied with selected standards in the following two activities:

- Patient Satisfaction Survey Scores.
- Suicide Prevention Program.

This report was prepared under the direction of Virginia L. Solana, Director, Denver and Los Angeles Offices of Healthcare Inspections.

Comments

The VISN and SVAMC Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The SVAMC is a tertiary facility located in Spokane, WA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics (CBOCs) in Wenatchee, WA, and Coeur d'Alene, ID, and through a mobile clinic that visits an additional eight remote locations across the catchment area. The SVAMC is part of VISN 20 and serves a veteran population of about 100,000 throughout eastern Washington, northern Idaho, and western Montana.

Programs. The SVAMC provides primary care and inpatient services. It has 36 hospital beds and 34 community living center (CLC) beds.[1]

Affiliations. The SVAMC is affiliated with Pacific University and provides training for two optometry residents. It also has numerous other affiliations to provide training for other disciplines, including nursing and dentistry.

Resources. In FY 2008, medical care expenditures totaled more than $130 million. The FY 2009 medical care budget is $136 million. FY 2008 staffing was 737 full-time employee equivalents (FTE), including 40 physician and 204 nursing FTE.

Workload. In FY 2008, the SVAMC treated 24,730 unique patients and provided 8,843 inpatient days in the hospital and 9,442 inpatient days in the CLC. The inpatient care workload totaled 2,075 discharges—1,845 for the hospital and 230 for the CLC. The average daily census, including CLC patients, was 50. Outpatient workload totaled 258,471 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- Patient Satisfaction Survey Scores.
- QM.
- Suicide Prevention Program.

The review covered SVAMC operations for FY 2008 and FY 2009 through February 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the SVAMC (*Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, Washington,* Report No. 06-00025-86, February 15, 2006). The SVAMC had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 153 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant

enough to be monitored by the OIG until corrective actions are implemented. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Data Sharing Between Surgery Service and Infection Control Practitioner

In 2006, the SVAMC's Surgery Service reported 14 cases of urinary tract infections (UTIs) in post-operative urology patients to the VA National Surgical Quality Improvement Program (NSQIP).[2] A review of these cases did not identify a common cause. In 2007, the ICP, who was also SVAMC's NSQIP nurse reviewer, became involved in reviewing all urine and wound specimens that were positive for bacteria. The ICP determined that many bacteria in the urinary tract were becoming resistant to ciprofloxacin,[3] rendering this antibiotic ineffective in preventing UTIs.

The data gathered by the ICP enabled the Surgical Urology Department (SUD) to initiate a dual antibiotic (ciprofloxacin and nitrofurantoin) regimen in post-operative urology patients beginning in July 2008. Because NSQIP does not directly report bacteria causing UTIs, the link between bacterial resistance to ciprofloxacin and the subsequent need for an additional antibiotic may not have been discovered by the SUD or the NSQIP nurse reviewer independently. Since implementation of the dual antibiotic regimen, there have been no reported UTIs in post-operative urology patients.

Safety Procedures for Methadone Use

In early 2008, the SVAMC received a VISN 20 best practice award for implementing procedures to optimize safe use of methadone.[4] The processes implemented include pharmacist review, patient education, and an annual evaluation. All new methadone orders are placed on hold until clinical pharmacists have determined the appropriate dosage and potential drug-drug interactions. In addition, before the first dose is dispensed, pharmacists verify that providers have completed and documented the required patient education. Pharmacy Service performs an annual

[2] The VA NSQIP was established in 1994 to monitor and improve the quality of surgical cases across all VHA facilities. More than 100,000 major surgical cases are added to the database each year. There are currently over 1 million surgical cases in the VA NSQIP database.
[3] Ciprofloxacin is the antibiotic of choice for all post-operative urology patients. It is used to prevent infections.
[4] Methadone is a drug used for pain management and addiction treatment.

medication use evaluation to ensure compliance with these safety procedures.

Environmental Achievement Award

In May 2008, the SVAMC received the "Partner for Change Award" for developing successful pollution prevention programs and for making quality patient care and the environment a priority. This award recognizes facilities that are helping to create healthy, healing environments and are committed to reducing waste and pollution. In 2007, the SVAMC saved more than $18,000 by recycling 43 percent of its waste. The SVAMC continually evaluates its processes in order to implement environmentally conscious practices.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the SVAMC's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the SVAMC's Director, Chief of Staff, and Quality Manager. We also interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the SVAMC's quality of care. Appropriate review structures were in place for 11 of the 15 program activities reviewed. However, we identified four areas that needed improvement.

Physician Privileges and Profiles. VHA regulations[5] require privilege forms to conform to certain formats. We reviewed 15 credentialing and privileging folders, and we noted irregularities, including blank signature blocks and inappropriate privilege attachments, in 7 (47 percent) of the 15 privilege request forms.

VHA regulations also require a thorough written plan with specific competency criteria for continuous performance monitoring for all privileged physicians. The SVAMC's written plan needed service-specific competency criteria. Two (13 percent) of the 15 physician profiles reviewed did

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

not have evidence of performance data for the 2-year period prior to reprivileging. In addition, Executive Committee of the Medical Staff meeting minutes did not reflect detailed discussion of any physician's performance data prior to reprivileging.

In addition, VHA regulations require that when physicians are given appointments of less than 2 years, privileges are to be granted for the same period of time. Until recently, privileges had routinely been granted for 2 years, regardless of the length of appointment.

Recommendation 1 We recommended that the VISN Director ensure that the SVAMC Director requires that privilege forms, the continuous performance review plan, provider profiles, and privileges are in compliance with VHA requirements.

The VISN and SVAMC Directors agreed with the findings and recommendation. Privilege form irregularities have been corrected, and clinical service chiefs received training. The SVAMC is in the process of re-evaluating its existing policy, and competency documentation is being improved. The target date for completion is July 31, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Documentation of Action Items. Accreditation standards require an effective communication process throughout the facility. Improvement was needed in documenting discussions about data analyses that were presented in committee meetings. Although Quality Council minutes documented discussions and actions needed for improvement, other high-level committees' meeting minutes did not. For example, although numerous programs and lower-level committees presented reports that identified problems to the Executive Leadership Committee and the Clinical Executive Board (CEB), we did not find consistent documentation that problems were discussed and that actions were taken.

Recommendation 2 We recommended that the VISN Director ensure that the SVAMC Director requires that committee chairpersons assure consistent documentation of discussions about QM data analyses and that they implement actions to address identified problems or trends.

The VISN and SVAMC Directors agreed with the findings and recommendation. The SVAMC will evaluate the effectiveness of committees and the quality of committee meeting minutes. A process will be established to ensure that concise action statements and target dates are defined and that follow-up is tracked. The target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Patient Complaints Data Management. VHA regulations[6] require that patient complaints data be gathered, critically analyzed, and incorporated into the facility's QM program. The SVAMC's patient advocate gathered complaint data and produced standard reports, but the analyses were not detailed enough to produce actionable items. Also, complaint trend reports were not presented regularly to appropriate leadership entities for discussion and action. For example, clinical trends should be presented to the CEB, and administrative issues should be presented to the Administrative Executive Board.

Recommendation 3 We recommended that the VISN Director ensure that the SVAMC Director requires that the patient advocate provides detailed patient complaint analyses and presents reports to appropriate venues for discussion and action.

The VISN and SVAMC Directors agreed with the findings and recommendation. The patient advocate will review the Patient Advocate Tracking System database quarterly, provide trended reports to appropriate venues, and track action plan follow-up. The target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Reconciliation. This national patient safety goal topic requires the SVAMC to maintain a list of all medications each patient takes. This list must be reviewed at key points during each patient's care, including admission, transfer, and discharge. Any medication duplications, omissions, or potentially hazardous combinations must be addressed or reconciled.

[6] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

Positive efforts were in place to monitor medication reconciliation in ambulatory care and at discharge from an inpatient stay. However, we did not find evidence of medication reconciliation monitoring at admission or transfer.

Recommendation 4 We recommended that the VISN Director ensure that the SVAMC Director requires that a process for comprehensive monitoring of medication reconciliation is established.

The VISN and SVAMC Directors agreed with the findings and recommendation. The SVAMC has developed a medication reconciliation progress note template. Responsibility for monitoring medication reconciliation has been assigned, and a goal of 90 percent has been set. The target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the SVAMC maintained a clean, safe, and secure environment. VHA facilities are required to establish comprehensive EOC programs that fully meet VHA, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the primary care, radiology, dental, and eye clinics and all inpatient units. We also inspected the main laboratory and the behavioral health and substance abuse center. Overall, we found the areas we inspected to be clean and well maintained, and managers expressed satisfaction with the housekeeping staff assigned to their areas.

We identified several issues that required managers' attention, such as unprotected patient information, security, and general maintenance. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these issues. However, we identified additional conditions that needed improvement.

Infection Control and Safety. VHA facilities are required to implement and maintain effective infection control and safety programs. In the CLC, we found cloth pull-cord extenders used for overhead lights in several patient rooms and a fire sprinkler impeded by a patient lift track.

Managers outlined plans to replace cloth extenders with materials that are easily cleaned and disinfected (for example, plastic bead material) and agreed to inspect all patient rooms to ensure that appropriate fire safety measures are in place.

In the locked mental health (MH) unit, we found that bedside and bathroom call buttons did not have extenders or cords that were accessible from the floor. Program managers informed us that they were in the process of selecting the appropriate materials for the call cords. In addition, we determined that the Multidisciplinary Safety Inspection Team (MSIT) for this unit did not include a psychiatrist and a representative from Environmental Management Service (EMS).

In several locations throughout the SVAMC, we identified sharps containers (used for safe disposal of used needles and sharp objects) that did not fully meet OSHA's requirement related to installation height. While we were onsite, program managers initiated work orders for proper mounting/installation of all sharps containers.

Recommendation 5 We recommended that the VISN Director ensure that the SVAMC Director takes action to address identified infection control and safety deficiencies.

The VISN and SVAMC Directors agreed with the findings and recommendation. Cloth pull-cords extenders in the CLC were replaced. All areas with overhead patient lift tracks were evaluated, and in areas where the tracks impeded the sprinklers, the sprinkler heads were moved. All call buttons in the locked MH unit now have vinyl cord extensions that have been deemed safe. A psychiatrist and an EMS representative have been added to the MSIT. Sharps containers throughout the SVAMC were evaluated for compliance with OSHA height requirements, and those that were not within the required parameters were moved to the requisite range. The corrective actions are acceptable, and we consider this recommendation closed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility emergency/urgent care operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute MH conditions and patients transferred to other facilities),

staffing adequacy, and staff competency. In addition, we inspected the SVAMC's ED for cleanliness and safety.

The ED is located within the main hospital building and is open 24 hours per day, 7 days per week. The emergency services provided are within the SVAMC's patient care capabilities.

We interviewed program managers and the VISN Integrated Referral System coordinator. We reviewed documents, including competency files, credentialing and privileging folders, and the medical records of patients who presented to the ED with acute MH conditions. In all cases, we found that staff managed patients' care appropriately. We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. However, we identified one area that needed management attention.

Nurse Competencies. Competencies were not completed annually for 5 (29 percent) of the 17 ED nurses. In addition, for 6 (35 percent) of the 17 nurses, competency folders did not contain documentation of completion of one or more competency elements. While we were onsite, program managers outlined plans to ensure that competencies are current and that the competency database and competency folders reflect accurate information.

Recommendation 6 We recommended that the VISN Director ensure that the SVAMC Director requires that ED nursing staff competencies are completed and current, as required.

The VISN and SVAMC Directors agreed with the findings and recommendation. The SVAMC will revise the current nursing competency policy and develop a form for the required competencies. ED staff will complete annual competency requirements. The ED nurse manager will monitor staff competencies and report monthly to nursing management. The target date for completion is June 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the

continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to optimal patient outcomes.

We reviewed randomly selected records for the 1st quarter of FY 2009. We found timely responses for all 25 of the inpatient consultations we reviewed. In addition, we reviewed the medical records of patients who transferred between units. In 18 (95 percent) of the 19 records reviewed, we found appropriate transfer documentation and timely patient assessments by receiving unit nursing staff. We identified one area that needed improvement.

Discharge Documentation. We reviewed the medical records of 23 patients who were discharged from the SVAMC. In all cases, we found documentation that patients or their family members understood and received copies of discharge instructions. However, we found inconsistent discharge documentation in 7 (30 percent) of the 23 medical records we reviewed. We identified inconsistencies between physician orders and discharge summaries for diet, activity level, and recommendations for follow-up care.

Recommendation 7 We recommended that the VISN Director ensure that the SVAMC Director requires that physician orders and discharge summaries are consistent.

The VISN and SVAMC Directors agreed with the findings and recommendation. Training on discharge documentation consistency will be provided to clinicians. Documentation will be monitored monthly, and a compliance goal of 95 percent has been set. The target date for completion is October 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. In addition, we assessed the extent that VHA facilities were monitoring SMP patients.

We reviewed selected medication management processes in the inpatient medicine/surgery, MH, and CLC units. We found adequate management of medications brought into the facility by patients or their family members and

appropriate use of patient armbands to correctly identify patients prior to medication administration. In addition, we found timely reconciliation of controlled substances discrepancies at the unit level. We identified two areas that needed improvement.

Pain Medication Effectiveness Documentation. On all inpatient units we reviewed, nurses generally assessed the effectiveness of PRN (as needed) pain medications administered to patients at all times. However, in 12 (17 percent) of the 70 doses reviewed, nurses did not consistently document the effectiveness of the medication within 4 hours, as required by local policy. The range of compliance with timely documentation was 73–91 percent. An SVAMC team developed an innovative automated program for monitoring timeliness of documentation, and more recent reviews have shown significant improvements.

Self-Medication Program. The SMP is designed to promote patient independence prior to discharge. The purpose is to instill in patients the ability to understand, participate in, and accept responsibility for their own health care. The SVAMC had a policy that specified several precautions that must be observed (including accurate selection of candidates and extensive patient education) before patients are enrolled in the program. We determined that the SVAMC could strengthen oversight of this program. CLC program managers acknowledged that they have not had a systematic process for monitoring and tracking patients in the SMP since 2004. While we were onsite, managers outlined plans to improve program oversight.

Recommendation 8 We recommended that the VISN Director ensure that the SVAMC Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe and that CLC managers develop a systematic process for monitoring SMP patients.

The VISN and SVAMC Directors agreed with the findings and recommendation. Training on pain medication effectiveness documentation was provided to nursing staff. Data on effectiveness documentation will be gathered and monitored, and results will be reported quarterly to the Pain Management Committee. The SMP manager has developed a tracking document to monitor all SMP enrollees and will report compliance regularly to the appropriate committee. The target date for completion is June 30, 2009.

The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent that VHA medical centers use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figures 1 and 2 below and on the next page show the SVAMC's patient satisfaction performance measure results for inpatients and outpatients, respectively.

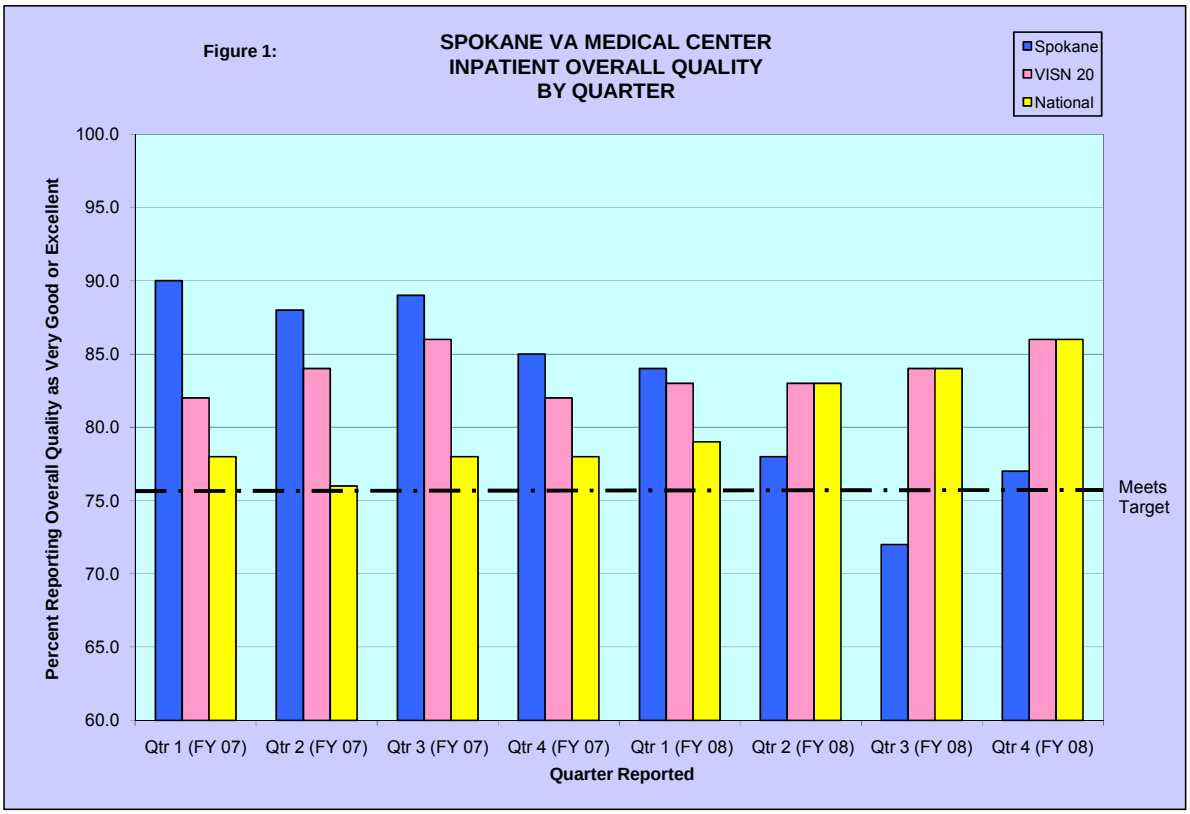
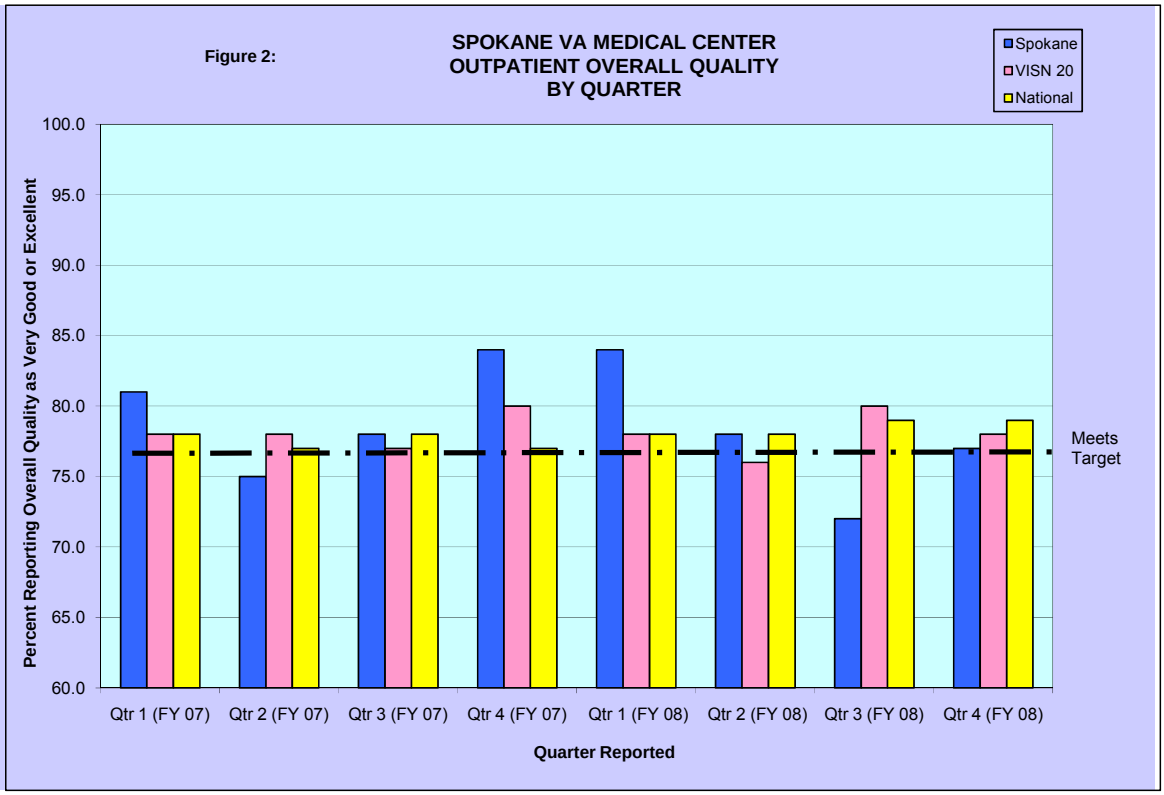


Figure 2:



The SVAMC met or exceeded the established target for inpatient overall quality in 7 of the last 8 quarters and met or exceeded the established target for outpatient overall quality in 6 of the last 8 quarters. Therefore, we made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether VHA facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs,[7] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[8] documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the SVAMC SPC, and we reviewed pertinent policies and the medical records of eight SVAMC

[7] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[8] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

patients and two CBOC patients determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required functions. We also found that documentation was complete in all medical records reviewed. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2009

From: Network Director, VISN 20 (10N20)

Subject: **Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, Washington**

To: Director, Denver and Los Angeles Offices of Healthcare Inspections (54DE/LA)

Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report from the March 16–19, 2009, Combined Assessment Program Review of the Spokane VA Medical Center.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have any questions or need further information, please contact Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949.

(original signed by:)
Susan Pendergrass, DrPH

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2009

From: Director, Spokane VA Medical Center (668/00)

Subject: **Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, Washington**

To: Director, Denver and Los Angeles Offices of Healthcare Inspections (54DE/LA)

Director, Management Review Service (10B5)

Thru: Director, Northwest Network (10N/20)

1. Thank you for the opportunity to review the draft report from the Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, Washington, dated April 14–16, 2009. I concur with the implementation plans as described and the established target dates.

2. The medical center carefully reviewed all items identified as opportunities for improvement and concurred in the recommendations that were made.

3. If you have any questions, or need further information, please contact Betty Braddock at (509) 434-7300.

(original signed by:)
Sharon M. Helman

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

Recommendation 1. We recommended that the VISN Director ensure that the SVAMC Director requires that privilege forms, the continuous performance review plan, provider profiles, and privileges are in compliance with VHA requirements.

Concur.

Target date of completion: July 31, 2009

Planned Actions:

All credential files were reviewed for irregularities and corrected.

Service Chiefs will continue to review performance data and report at least every 6 months, per our professional practice evaluation policy. Thorough discussion of ongoing professional practice evaluation data will be included in the Executive Committee of the Medical Staff (ECMS) committee minutes.

Retraining was given to clinical service chiefs on utilizing the "Practitioner Privileging and Profile for Practitioner Competency" guidance document from the VHA Office of Quality and Performance. Specific practitioner profile samples were also provided to the clinical service chiefs.

The SVAMC is evaluating its existing policy by reviewing other facility's best practices.

The SVAMC will continue thorough review of every privilege a provider requests. Additionally, the SVAMC will document competence to do the requested service specific privilege. The SVAMC will develop targets and actions needed before a provider is approved for a privilege. These targets will create minimum threshold criteria for requesting a privilege and guidance on how many procedures a provider should complete to maintain a privilege. Additionally, targets will establish what actions are needed before a provider is approved for a privilege.

Recommendation 2. We recommended that the VISN Director ensure that the SVAMC Director requires that committee chairpersons assure consistent documentation of discussions about QM data analyses and that they implement actions to address identified problems or trends.

Concur.

Target date of completion: September 30, 2009

Planned Actions:

The SVAMC will launch a quality improvement process to evaluate the effectiveness of committees. The quality minutes will be assessed and a process established to ensure the standardized minutes format is used, concise action statements and target dates are defined when appropriate, and follow-up is traceable through multiple sets of minutes.

Recommendation 3. We recommended that the VISN Director ensure that the SVAMC Director requires that the patient advocate provides detailed patient complaint analyses and presents reports to appropriate venues for discussion and action.

Concur.

Target date of completion: September 30, 2009

Planned Actions:

The Patient Advocate will review the Patient Advocate Tracking System database at the end of each quarter. The Patient Advocate will regularly provide trended patient complaint data reports to appropriate venues, including the Patient & Employee Satisfaction Committee (PESC), Clinical Executive Board (CEB), Leadership, and any other committee deemed appropriate by the Patient Advocate. Service chiefs will develop and implement action plans. Follow-up of action plans will be tracked by the Patient Advocate and reported to the PESC.

Recommendation 4. We recommended that the VISN Director ensure that the SVAMC Director requires that a process for comprehensive monitoring of medication reconciliation is established.

Concur.

Target date of completion: September 30, 2009

Planned Action:

The SVAMC has developed a standardized inpatient medication reconciliation template in the computerized patient record System for admit, discharge, and transfer. The Medicine Service Clinical Applications Coordinator will send an update out to all SVAMC clinicians who work in inpatient settings on how to access the medication reconciliation template.

The Associate Chief of Medicine/Surgery has the responsibility to monitor providers' charts and ensure that the standardized template is implemented with each admission, transfer, and discharge. The Medicine Service Administrative Assistant will perform monthly audits on providers until a 90 percent threshold is met. Once the 90 percent threshold is met, audits will be decreased to quarterly. Audit reports will be submitted monthly to the Patient Safety Manager for evaluation and follow-up action as appropriate and report to CEB quarterly.

Recommendation 5. We recommended that the VISN Director ensure that the SVAMC Director takes action to address identified infection control and safety deficiencies.

Concur.

Target date of completion: Complete

Planned Actions:

There were five separate infection control and safety deficiencies identified. All five of these items have been completed.

1. Cloth pull-cords extenders in the Community Living Center (CLC) have been replaced with a vinyl cord, which has a 12# test breaking point. All CLC rooms now have this vinyl cord.

2. All areas with overhead patient lift tracks were evaluated for sprinkler impediment. In all areas where patient lift tracks were discovered to impede the sprinkler system, the sprinkler heads were moved to eliminate the impediment.

3. All bedroom and bathroom call buttons in the locked mental health unit have vinyl cord extensions in place, which allow for call button activation from the floor. This vinyl cord has a 12# test breaking point and has been evaluated for patient safety by the MSIT.

4. A psychiatrist and an Environmental Management Service representative have been added to the MSIT.

5. All sharps containers throughout the hospital have been evaluated for compliance with OSHA height requirements. Those that were not within the required height parameters, as set forth by OSHA, have been moved to the required height range.

Recommendation 6. We recommended that the VISN Director ensure that the SVAMC Director requires that ED nursing staff competencies are completed and current, as required.

Concur.

Target date of completion: June 30, 2009

Planned Action:

All ED staff will complete annual competency requirements. These competencies will be documented and placed in the staff member's competency folder upon completion. The ED Nurse Manager will monitor staff competencies and report to the Chief of Nursing and the Nursing Executive monthly with a competency status.

The SVAMC will revise its current nursing competency policy to clearly delineate which nursing competencies will be required annually (every 12 months) and which competencies will be required once per fiscal year.

The Education Department will develop a required annual competency form, which will include "Date Required" and "Date Completed" for each individual competency. Each staff member will have their own form kept in their competency folder.

Recommendation 7. We recommended that the VISN Director ensure that the SVAMC Director requires that physician orders and discharge summaries are consistent.

Concur.

Target date of completion: October 30, 2009

Planned Action:

The Associate Chief of Staff for Medicine/Surgery (ACOSMS) will educate all SVAMC hospitalists in the necessity to ensure that discharge orders and discharge summaries are consistent with each other. This education will consist of review of SVAMC's current policy NM 136-27-09 entitled "Medical Records." Specific focus within NM 136-27-09 will center on Section 12, which defines provider responsibility in completing discharge orders and discharge summaries. Additionally, the ACOSMS will review the OIG findings and recommendations with the hospitalists. The ACOSMS will have signed documentation from each hospitalist illustrating receipt and review of the above mentioned education items.

All physician discharge summaries and orders will be monitored monthly, specifically related to section 12. A compliance goal of 95 percent has been set.

Recommendation 8. We recommended that the VISN Director ensure that the SVAMC Director requires that nurses consistently document the

effectiveness of all pain medications within the required timeframe and that CLC managers develop a systematic process for monitoring SMP patients.

Concur.

Target date of completion: June 30, 2009

Planned Action:

PRN Pain Effectiveness:

All nursing staff working the inpatient areas will review policy 11-16-09 (Bar Code Medication Administration) to ensure understanding of required PRN effectiveness documentation within 4 hours of pain medication administration. (Complete)

Utilizing Spokane VAMC's automated program, data on PRN effectiveness documentation will be generated on a weekly basis until the expected threshold of 90 percent has been achieved for no less than 8 consecutive weeks. Data will then be gathered on an ongoing monthly basis. (Complete/Ongoing)

Monitors will be developed in order to ensure a standardized method of evaluating and reporting compliance. Results will be reported to the Pain Management Committee on a quarterly basis.

Weekly and monthly reports of compliance will be provided to the Chief of Nursing Service for review. The Chief of Nursing Service will follow up immediately with nurse managers regarding those nursing staff members who are not documenting as per policy. (Ongoing)

Self-Medication Program:

Candidates for the Self Medication Program (SMP) in the CLC are discussed during the Care Plan Conference with the SMP Manager present. Residents are enrolled into the program after selection criteria is met. The SMP Manager has developed a tracking document to monitor all residents enrolled in the SMP. The SMP Manager will monitor and report policy compliance regularly to the CLC CQI meeting with current enrollment and any concerning issues surrounding the program. Regular documentation is done in the patient education notes by the SMP Manager.

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