Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-02921-57

Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

January 5, 2010

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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Executive Summary

Introduction

During the week of September 21–24, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Roseburg Healthcare System (the system), Roseburg, OR. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). The system 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 strength and reported accomplishment:

- Employee Influenza Program.

We made recommendations in four of the activities reviewed. For these activities, the system needed to:

- Require management to maintain comprehensive QM program documentation, monitoring, tracking, and timely reporting to oversight committees.
- Require nurses to consistently document the effectiveness of as needed (PRN) pain medications in accordance with local policy.
- Require pharmacists to consistently perform and document community living center (CLC) monthly medication reviews.
- Ensure that the recently adopted Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) plans are fully implemented.
- Validate that contracted/agency registered nurses (RNs) have completed mandatory training, have presented evidence of clinical competence, and have documentation of completed background investigations prior to providing patient care.

The system complied with selected standards in the following three activities:

- Coordination of Care.
- Environment of Care (EOC).
- Magnetic Resonance Imaging (MRI) Safety.

This report was prepared under the direction of Virginia L. Solana, Director, Denver Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 11–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by Dana Moore, PhD,
Deputy Assistant Inspector General for Healthcare Insepctions for:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system is a primary medical, mental health (MH), and surgical facility located in Roseburg, OR, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Brookings, Eugene, and North Bend, OR. Additionally, the system operates a Community Reintegration Services Center in Eugene, OR. The system is part of VISN 20 and serves a veteran population of about 62,000 throughout central and southern Oregon and northern California.

Programs. The system provides medical, surgical, MH, protective care, transitional care, and reintegration services. It has 68 hospital beds and 55 CLC beds.

Affiliations and Research. The system is affiliated with Umpqua and Mt. Hood Community Colleges, Graceland University, Gonzaga University, the University of Portland, and Oregon Health and Science University. The system provides a 4 to 8 week rotation for family practice residents in specialty procedures. It also provides training for undergraduate and graduate nursing, dietetic, health care administration, pharmacy, social work, emergency medical technology, optometry, and computer technology programs.

Resources. In fiscal year (FY) 2009, medical care expenditures totaled $124 million. FY 2009 staffing was 783 full-time employee equivalents (FTE), including 40 physician and 269 nursing FTE.

Workload. In FY 2009 through September 27, 2009, the system treated 24,823 unique patients and provided 12,557 inpatient days in the hospital and 11,351 inpatient days in the CLC unit. The inpatient care workload totaled 2,301 discharges, and the average daily census, including CLC patients, was 90. Outpatient workload totaled 232,749 visits.

Objective and Scope

Objective. 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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

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:

- Contracted/Agency RNs.
- Coordination of Care.
- EOC.
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging (C&P).
- QM.

The review covered system operations for FY 2008 and FY 2009 through July 13, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon,* Report No. 06-02817-42, December 13, 2006). The system had corrected all findings related to health care from our prior CAP review.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Employee Influenza Program

The Employee Influenza Program has significantly improved from 1999 to 2009. The flu vaccination rate has increased from 43 percent to 82 percent for employees and from 38 percent to 82 percent for volunteers. The success of the program is due to increased education, direct contact with

staff, increased facility leadership and support, implementation of tracking and documentation, and improved vaccination accessibility. The system has exceeded the Veterans Health Administration's (VHA's) occupational health influenza vaccine performance measure.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to evaluate whether (a) the system had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements.

The QM program was generally effective in providing oversight of the system's quality of care. Also, it was evident that senior managers supported the program through participation in and evaluation of performance improvement (PI) initiatives. However, we identified the following area that needed improvement.

Program Documentation, Monitoring, Tracking, and Reporting. Consistent documentation of PI activities, monitoring of outcomes, and tracking of goals were needed to improve the QM/PI programs reviewed. Also, quarterly reports to oversight committees needed to be submitted in a timely manner.

Examples of program shortfalls included:

- Current Basic Life Support training was not documented for 25 (5 percent) of 485 employees required to have life support training.
- Monitoring of medication reconciliation for intra-facility transfers was not documented until the last quarter of FY 2009.
- Moderate sedation adverse events, such as use of assisted ventilation, unplanned admissions, and untoward drug events, were not monitored, tracked, or reported.

- One of four quarterly Peer Review Committee reports was not submitted to the Executive Committee of the Medical Staff.
- Three (23 percent) of 13 individual root cause analysis reviews completed in FY 2009 prior to June 2009 were not completed within 45 days, as required by VHA.[1]
- Two of four patient complaint reports were not submitted to a senior-level QM/PI committee.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires comprehensive QM program documentation, monitoring, tracking, and timely reporting to designated oversight committees.

The VISN and System Directors concurred with the findings and recommendation. The system implemented actions and standing agenda items to address program documentation, monitoring, tracking, and timely reporting to designated oversight committees. For example, the system revised the process for monitoring life support training and implemented mechanisms to monitor moderate sedation adverse events. The implementation 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 developed effective and safe medication management practices. We reviewed selected medication management processes on the inpatient medical/surgical, locked MH, intensive care, and CLC units.

We reviewed the documentation provided and found that the designated Bar Code Medication Administration (BCMA) Program Coordinator had appropriately identified and addressed problems. We also reviewed a "PRN Reason Report" dated August 9–11, 2009. Medical records contained documentation that 19 doses of insulin had been given for elevated blood pressure instead of elevated blood sugar. Managers promptly corrected the problem by modifying BCMA reason codes while we were onsite. We determined this corrective action to be acceptable and made no recommendation for this finding. However, we identified the following two areas that needed improvement.

Documentation of Pain Medication Effectiveness. Nurses did not consistently document the effectiveness of PRN pain

[1] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

medications in accordance with local policy requirements. We reviewed the BCMA records of 22 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses documented pain medication effectiveness within the locally required timeframe of 4 hours for only 39 (34 percent) of the 115 doses of pain medications reviewed. An action plan to address delays in documenting pain medication effectiveness was implemented in August 2009.

CLC Monthly Medication Reviews. Accreditation standards require that a pharmacist review each CLC patient's medication each month to identify any problems, such as interactions or duplications. Pharmacists did not consistently document monthly medication reviews for any of the 11 CLC patients whose records we reviewed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that nurses consistently document the effectiveness of PRN pain medications within the required timeframe of the local policy.

The VISN and System Directors concurred with the findings and recommendation. Nurses have been re-educated on documenting the effectiveness of PRN medications. In addition, the local medication administration policy has been updated. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that pharmacists consistently perform and document CLC monthly medication reviews.

The VISN and System Directors concurred with the finding and recommendation. The system developed a template for documenting monthly CLC medication reviews. Chart reviews are being conducted, and data will be discussed monthly at Geriatric and Extended Care Committee meetings. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[2]

We reviewed 12 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. We identified the following area that needed improvement.

OPPE and FPPE. The new plans for OPPE and FPPE were implemented August 29, 2009, and appear to be appropriate. However, OPPE and FPPE data for the 12 physicians re-privileged within the last year were not sufficient to meet current requirements.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that the recently adopted OPPE and FPPE plans are fully implemented.

The VISN and System Directors concurred with the findings and recommendation. The system developed a tracking method to identify which providers are due for FPPE or OPPE and to ensure timely completion of the processes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed seven files of contracted/agency RNs who worked at the system within the past year. We reviewed documents for several required components, including background investigations, licensure, training, and competencies. We identified three areas that needed improvement.

Training. VA and VHA require several training courses for staff as well as contracted/agency RNs.[3] We did not find evidence that all mandatory training was completed. For example, we found no documentation of the required VHA information security training and VHA privacy policy training for three of the seven contracted/agency RNs. However,

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

these RNs had access to VHA computer systems, which include patient information.

Clinical Competence. According to local policy, contracted/agency RNs are expected to present documented evidence of current clinical competence before providing patient care. We found competency documentation for only five of the seven contracted/agency RNs.

Background Investigations. U.S. Government agencies are required to complete background investigations for employees in sensitive positions.[4] We found documentation of completed background investigations for six of the seven contracted/agency RNs.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires nursing managers to validate that contracted/agency RNs have completed mandatory training, have presented evidence of clinical competence, and have documentation of completed background investigations prior to providing patient care.

The VISN and System Directors concurred with the findings and recommendation. The system developed a process for maintaining nursing competencies, evidence of mandatory training, and evidence of completed background checks. Information will be readily available in the Nursing Service office. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and Joint Commission (JC) requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the documentation for 15 intra-facility transfers and determined that clinicians appropriately managed all transfers. We found transfer notes from sending to receiving units and documentation that nursing assessments were

[4] Executive Order 10450; *Security Requirements for Government Employment;* April 27, 1953; Sec. 3.

performed by the receiving units in accordance with established timeframes.

We reviewed the medical records of 12 patients who were discharged and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions.

Additionally, we reviewed the medical records of three patients recently discharged from the locked MH unit. We found documentation that patients received information about accessing emergency MH care and that patients were given MH clinic appointments within 2 weeks of discharge. We also found documentation that MH providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. We made no recommendations.

Environment of Care

The purpose of this review was to determine whether the system complied with selected infection control standards and maintained a clean, safe, and secure environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, National Fire Protection Association, Occupational Safety and Health Administration, and JC standards.

We inspected the locked MH, substance abuse, protective care, transitional care, inpatient medical/surgical, intensive care, and short stay units. We also inspected the Specialty Care and Primary Care White Team outpatient clinics. Overall, we found that the system maintained a generally clean and safe environment. The infection control program monitored exposures and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. Managers on the locked MH unit complied with safety regulations, and staff were trained to identify environmental hazards. We made no recommendations.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key

personnel. We determined that the system had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have been conducted in the MRI area.

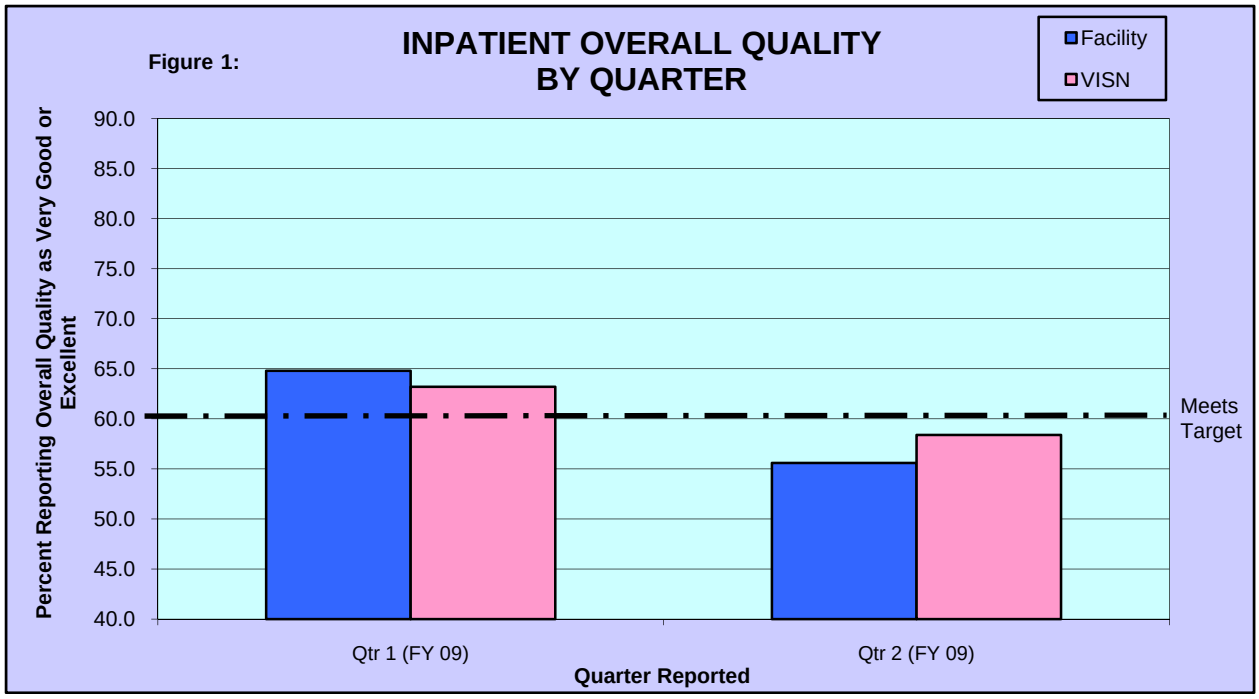
Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 22 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. In addition, three patients who had an MRI with contrast media had signed informed consents prior to their procedures, in accordance with local policy. We made no recommendations.

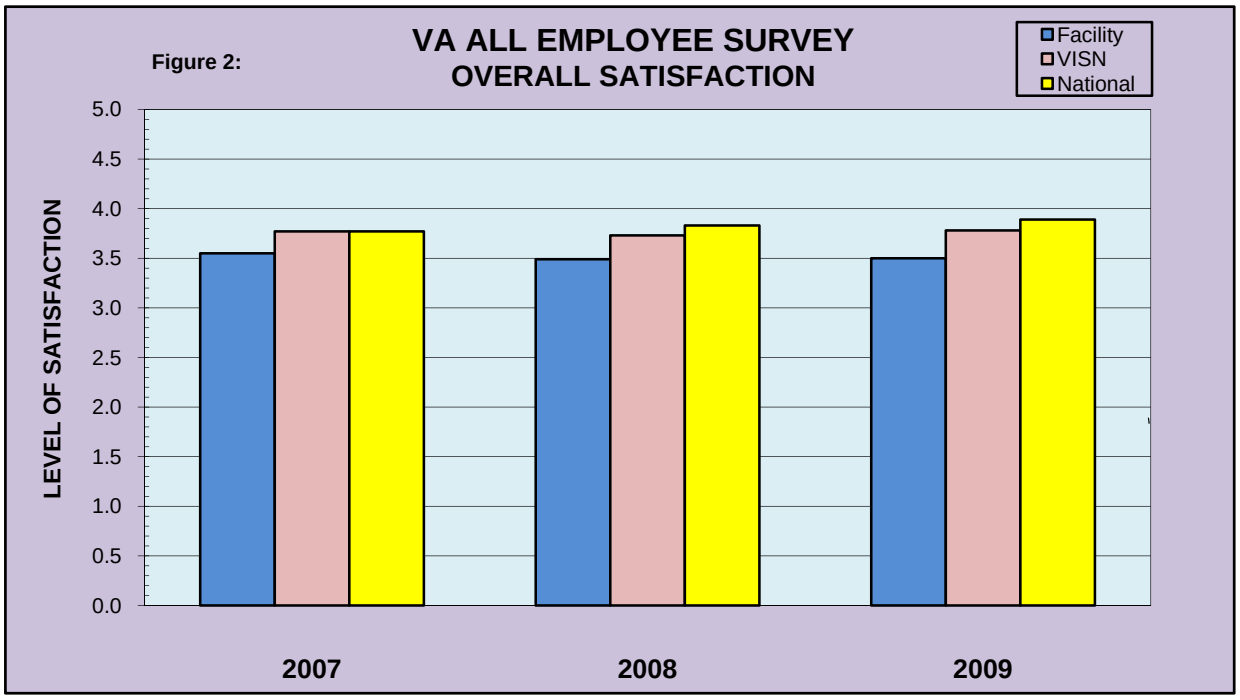
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1 and 2 of FY 2009. [5] Target scores are noted on the graph.

[5] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 2 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 4, 2009

From: Director, Northwest Network (10N20)

Subject: **Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General Combined Assessment Program survey comments and implementation plan from the Roseburg VA Healthcare System, Roseburg, Oregon.

2. If you have any questions regarding this report, please contact Jennifer Strawn, Quality Manager at (541) 440-1358.

(original signed by:)
Susan Pendergrass, DrPH

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 3, 2009

From: Director, VA Roseburg Healthcare System (653/00)

Subject: **Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon.**

To: VISN Director, Northwest Network (10N20)

1. On behalf of the VA Roseburg Healthcare System, Roseburg, Oregon, I would like to express my appreciation to the Office of Inspector General Survey Team for their professional and comprehensive CAP review conducted September 21–24, 2009.

2. We have reviewed the findings from the report. The facility responses addressing each recommendation are attached. The responses include actions that are in progress and those that have already been completed.

(original signed by:)
Susan Yeager

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:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires comprehensive QM program documentation, monitoring, tracking, and timely reporting to designated oversight committees.

Concur

Facility's response: Following are the individual program shortfalls identified by the site visit team. Actions for each of these items are individually listed. In addition to the individual actions listed below, the Quality Review Council has adopted a standing agenda that meets the requirements of VHA Directive 2009-043, *Quality Management System*. This will help to ensure that timely data collection and analysis continues to occur for key processes.

Current Basic Life Support training was not documented for 25 (5 percent) of 485 employees required to have life support training.

Action: We have revised the process for monitoring BLS and ACLS:

1. A comprehensive tracking sheet consisting of all employees who are required to have BLS and/or ACLS, per job responsibility, has been created. The tracking sheet is broken down into service level and month that the BLS and/or ACLS are due.
2. Electronic correspondence is provided to both the staff and the supervisor to alert them when their BLS or ACLS is due.
3. Quarterly reports of compliance and upcoming due dates are provided to service managers.
4. The tracking mechanism is in place for employees who are registered to receive training updates but do not receive the training.
5. Centralized scheduling has been created for the BLS and/or ACLS classes.

Target Completion Date: December 31, 2009.

Monitoring of medication reconciliation for intra-facility transfers was not documented until the last quarter of FY 2009.

Action: As noted by the OIG-CAP team at the time of the review, we began monitoring in the last quarter of FY 2009. Data collection is ongoing, and results are reported on a monthly basis to the Quality Management Service.

Target Completion Date: Completed September 30, 2009.

Moderate sedation adverse events, such as the use of assisted ventilation, unplanned admissions, and untoward drug events, were not monitored, tracked, or reported.

The team noted that perioperative occurrences for procedures done in the operating room (OR) and those done outside of the OR were not separately tracked—they were aggregated together. Since the review, separate tracking mechanisms have been developed for the OR and non-OR occurrences. The following occurrences are being monitored:

1. Complications.
2. Death.
3. Clean wound infections.
4. Returns to the OR.
5. Admission within 14 days of the procedure.
6. Delays from the Post Anesthesia Care Unit to follow up care.
7. Use of reversal agents.

Target Completion Date: Completed October 1, 2009.

One of four quarterly Peer Review Committee reports was not submitted to the Executive Committee of the Medical Staff (ECMS).

As noted by the OIG-CAP review, three of the quarterly reports were submitted to the ECMS. The ECMS now has a standing agenda item to assure that the Peer Review Committee reports are submitted and reviewed on a quarterly basis. The most recent quarterly review was submitted November 19, 2009.

Target Completion Date: Completed November 19, 2009.

Three (23 percent) of 13 individual Root Cause Analysis reviews completed in FY 2009 prior to June 2009 were not completed within 45 days as required by VHA.

A Tetrad member is included half-way through the RCA process to ensure timeliness of the analysis and appropriateness of actions, so that the report and recommendations can be signed by the Director or her surrogate in a timely manner.

Target Completion Date: Completed November 10, 2009.

Two of four patient complaint reports were not submitted to a senior-level QM/PI committee.

The Quality Review Council has added this quarterly report to its standing agenda. The next quarterly report is due November 24, 2009.

Target Completion Date: Completed November 24, 2009.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that nurses consistently document the effectiveness of PRN pain medications within the required timeframe of the local policy.

Concur

Facility's response: The Executive Council of Nurses noted this was an issue in June of 2009. From this assessment the following interventions were undertaken:

1. Nurses have been educated on the purpose of documenting the effectiveness of PRN medication.
2. Nurses are monitored on documentation of PRN effectiveness through on-going chart reviews.
3. It is a standing review at the monthly Executive Council of Nurses meeting.
4. We have revised MCM 1442, *Medication Administration using BCMA*.

Target Completion Date: Expect 90 percent compliance by December 31, 2009.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that pharmacists consistently perform and document CLC monthly medication reviews.

Concur

Facility's response: The following interventions were undertaken:

1. A template was developed to assist the pharmacist with efficiently documenting review findings in the patient's electronic medical record. The pharmacist is now doing this on all patients in the Community Living Center.
2. This is being monitored by chart reviews, and the data is discussed monthly at the Geriatric and Extended Care Committee.

Target Completion Date: Completed November 20, 2009.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the recently adopted OPPE and FPPE plans are fully implemented.

Concur

Facility's response: The OPPE/FPPE policy was implemented in August 29, 2009. There is a spreadsheet kept by the Chief of Staff Office which tracks and identifies which providers are due for FPPE or OPPE. The service line administrator initiates and manages the OPPE/FPPE process. The Chief of Staff Office tracks and ensures the timeliness and completion of the OPPE/FPPE processes. All new hires and providers who request new privileges undergo FPPE. A select group of providers require FPPE based on defined criteria outlined in the station policy.

Every 6 months, providers undergo OPPE. There have been 21 providers who have gone through the OPPE process since implementing the policy. As of November 30, 2009, there have been seven new providers privileged at the facility. One has completed the FPPE, four are in process, and two have not started yet. There are two providers who have triggered an FPPE. There are 11 providers due for OPPE during January through March 2010.

Target Completion Date: Completed November 30, 2009.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires nursing managers to validate that contracted/agency RNs have completed mandatory training, have presented evidence of clinical competence, and have documentation of completed background investigations prior to providing patient care.

Concur

Facility's response: The facility's understanding, regarding the nursing contract, was that once the nursing contract was completed the documents were no longer relevant. However, the OIG consultant recommended keeping the records for seven years. We are following the recommendations and have implemented the following corrective actions:

1. All contracted/agency nursing six-part folders will be kept for seven years in the Associate Chief Nurse Executive's locked file cabinet.
2. All contracted/agency nursing personnel will have all unit and service/facility competencies in their six-part folder in conjunction with a copy of their agency competency record.
3. All contracted/agency nursing personnel will have in their six-part folder evidence of required mandatory training.

4. All contracted/agency nursing personnel will have in their six-part folder evidence of VHA privacy policy training and VHA information security training.
5. All contracted/agency nursing personnel will have in their six-part folder evidence of complete background investigations.

Target Completion Date: Completed September 25, 2009.

OIG Contact and Staff Acknowledgments

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