Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03274-110

Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center Milwaukee, Wisconsin

March 18, 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.

To Report Suspected Wrongdoing in VA Programs and Operations
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Table of Contents

Executive Summary

Introduction

During the week of November 30–December 4, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Clement J. Zablocki VA Medical Center (the medical center), Milwaukee, WI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 56 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

The CAP review covered seven operational activities and one follow-up review area from the previous CAP review. We identified the following organizational strength and reported accomplishment:

- BE SAFE initiative embraced by patients and staff.

We made recommendations in six of the activities reviewed and in the follow-up review area. Additionally, we identified three repeat findings related to environment of care (EOC) and cardiac catheterization laboratory (CCL) standards from our prior CAP review of the medical center. For these activities and the follow-up review area, the medical center needed to:

- Document extensions for peer reviews (PRs) that exceed 120 days, in accordance with Veterans Health Administration (VHA) policy.
- Ensure that designated staff maintain current cardiopulmonary resuscitation (CPR) and/or Advanced Cardiac Life Support (ACLS) certification and that a process is established to document, review, and track life support training.
- Correct the identified medication security, patient privacy, maintenance, and employee training concerns.
- Complete and document patient magnetic resonance imaging (MRI) screenings.
- Secure the MRI area.
- Ensure that providers complete discharge documentation in accordance with VHA policy.

- Ensure that patients discharged from the locked acute mental health (MH) unit receive timely post-discharge care and that care is documented, as required by VHA policy.
- Ensure that nursing personnel consistently assess and document PRN (as needed) pain medication effectiveness within the timeframe specified by local policy.
- Ensure that nurse managers validate the clinical competence of contracted/agency registered nurses (RNs) prior to patient care assignments.
- Complete the CCL informed consent process in accordance with VHA policy.

The medical center complied with selected standards in the following activity:

- Physician Credentialing and Privileging (C&P).

This report was prepared under the direction of Paula Chapman, Associate Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–23 for 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 medical center is a tertiary care facility located in Milwaukee, WI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics in Appleton, Cleveland, Green Bay, and Union Grove, WI. The medical center is part of VISN 12 and serves a veteran population of about 321,400 throughout central Wisconsin.

Programs. The medical center provides primary, secondary, and tertiary level services. It has 195 hospital, 113 community living center (CLC), and 356 domiciliary beds.

Affiliations and Research. The medical center is affiliated with the Medical College of Wisconsin and provides training for 153 residents. It also provides training for 37 allied fields, including nursing and pharmacy. In fiscal year (FY) 2009, the medical center's research program had 305 projects and a budget of $4.5 million. Important areas of research included adaptive device design, anesthesiology, cancer, cardiovascular electrophysiology, cardiology, crystal-related diseases, gastrointestinal motility, nephrology, neurology, physiology, rheumatology, spinal cord injury, trauma, prostate and bladder diseases, and prosthetics.

Resources. In FY 2009, medical care expenditures totaled $355.2 million. The FY 2010 medical care budget was pending at the time of our review. FY 2009 staffing was 2,241 full-time employee equivalents (FTE), including 158 physician and 957 nursing FTE.

Workload. In FY 2009, the medical center treated 58,416 unique patients and provided 47,331 inpatient days in the hospital and 30,290 inpatient days in the CLC. The inpatient care workload totaled 7,360 hospital discharges, and the average daily census, including CLC patients, was approximately 215. Outpatient workload totaled 629,706 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.
- 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 and follow-up review area:

- Contracted/Agency RNs.
- Coordination of Care.
- EOC.
- Follow-Up on CCL Standards.
- Medication Management.
- MRI Safety.
- Physician C&P.
- QM Program.

The review covered medical center operations for FY 2009 and FY 2010 through November 30, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin,* Report No. 07-00060-121, April 27, 2007). We identified three repeat findings from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 56 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 activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strength

BE SAFE Initiative Embraced by Patients and Staff

Through the initial interest and efforts of a part-time RN assigned to the intensive care unit (ICU) and the ongoing efforts of patient safety staff, medical center managers initiated a program entitled BE SAFE. The program encourages veterans to become involved in keeping health care safe for everyone. Staff have been educated on the initiative, and information regarding the program is provided to inpatients and outpatients. Upon admission, patients receive a writing pen and stationery to record any questions they may have for the members of their health care team. The acronym BE SAFE stands for:

- **Become** your own health care advocate.
- **Educate** yourself about your plan of care.
- **Seek** answers.
- **Avoid** medication errors.
- **Familiarize** yourself with your medical tests and treatments.
- **Empower** yourself to participate in safe health care everywhere.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the medical center's Director and Chief of Staff (COS) and selected QM staff. We evaluated plans, policies,

performance improvement (PI) data, and other relevant documents.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following areas that needed improvement.

PR Process. Once the need for a PR is determined, VHA policy[1] requires facilities to complete the PR within 120 days. Any exception or extension beyond 120 days must be requested in writing and approved by the medical center's Director, who is responsible for monitoring and reviewing the number of extensions twice a year.

We found that 9 (5 percent) out of 182 PRs completed in FY 2009 exceeded the 120-day timeframe. Extensions for these reviews were not documented, granted, or reviewed in accordance with VHA policy.

Life Support Training. We found that the medical center did not have a mechanism in place to ensure that designated staff maintained current CPR and/or ACLS certification, as required by local policy. Local policy requires that all clinically active staff must have CPR education. However, the term "clinically active" is not defined and has been interpreted differently throughout the medical center.

We found that 170 (19 percent) of 917 required staff were not current in CPR. ACLS is required for specific nursing employees and licensed independent practitioners (LIPs), as delineated in local policy. Data showed that 4 (4 percent) of the 94 identified nursing employees and 36 (32 percent) of the 111 LIPs were not current in ACLS. Life support training needed to be consistently documented, reviewed, and tracked to ensure compliance with local policy.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that PRs that exceed 120 days have documented extensions, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. A formal mechanism has

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

been developed to document extension requests, and the medical center now has a standard notification letter. A bi-annual summary of cases that have been granted extensions will be submitted to the COS and the Medical Center Director. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR and/or ACLS certification and that a process is established to document, review, and track life support training.

The VISN and Medical Center Directors concurred with the findings and recommendation. The medical center is revising its local policy to define clinically active staff who will be required to have CPR and/or ACLS training. A computerized tracking system that uses the Learning Management System (LMS) is being created. Program managers for non-LIPs will receive monthly LMS reports from Employee Education. LIPs will be tracked through the Medical Staff Credentialing Office. The implementation 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 whether the medical center complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), and Joint Commission (JC) standards.

We conducted onsite inspections of the locked acute MH unit, general unlocked MH unit, medical unit, surgical unit, telemetry unit, ICU, geriatric transitional care unit, CLC, and spinal cord injury (SCI) unit. We also inspected the emergency department, the radiology department, and three outpatient clinics. The medical center maintained a generally clean and safe environment. Nurse managers and staff expressed satisfaction with the responsiveness of the housekeeping staff on their units. Medical center managers conducted quarterly MH EOC assessments for the locked acute MH unit and were pursuing corrective actions. We identified the following areas that needed improvement.

Medication Security. During our prior CAP review, we identified medication security concerns as a finding. This finding had not been fully resolved. JC standards require all medications to be secured from access by unauthorized persons. We found an unlocked, unattended medication cart in a corridor on the telemetry unit. Also, on the ICU, we found vials of insulin in an unlocked room and in an unlocked corridor drawer.

Patient Privacy. During our prior CAP review, we identified patient privacy concerns as a finding. This finding had not been fully resolved. The Health Insurance Portability and Accountability Act requires sensitive patient information to be secured. We found that staff did not ensure that computer monitors were blocked from public view and locked when unattended, that papers with personally identifiable patient information were secured when unattended, and that video surveillance monitors for patient observation were blocked from public view.

Maintenance. In a corridor on the telemetry unit, we noted loose wallpaper that had been taped to the wall. On the SCI unit, the telemetry unit, and the geriatric transitional care unit, we noted non-slip strips in patient bathrooms that were not intact.

Employee Training. The medical center must provide training in environmental hazard identification during orientation and annually for all staff who work on the locked acute MH unit. We found that targeted staff had not received this training. We reviewed training records for 10 clinical staff and noted that 3 (30 percent) did not receive annual training on bloodborne pathogens, as required by OSHA.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the identified medication security, patient privacy, maintenance, and employee training concerns to be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. The program manager for the intravenous (IV) team reviewed cart security requirements with IV team members and instituted random monitoring. All insulin on the ICU was relocated to the locked medication room. Computer monitors were repositioned or relocated, and privacy screens were ordered. Education on patient information security requirements was provided. Facility

Management has reattached the wall coverings and repaired non-slip strips. Environmental hazard identification training is now included in new employee orientation and is mandatory for unit-specific annual training. Delinquent staff completed bloodborne pathogens training, and this training will be monitored annually to ensure completion. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center 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 medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by the JC.

Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner. We identified two areas that needed improvement.

Patient Screening. The JC recommends that trained personnel screen all non-emergent patients twice. This provides two separate opportunities for them to answer questions about any metal objects they may have on them; any implanted devices, drug delivery patches, tattoos; and any electrically, magnetically, or mechanically activated devices.

We reviewed the screening processes for 10 patients who had MRIs during September 2009. An MRI technologist completes a final patient screening prior to the MRI. This screening is to be documented on a template in the patient's electronic medical record. In our review of the 10 patients' medical records, we noted that final screenings were not documented in 3 (30 percent) of the records.

Environmental Safety. We evaluated the MRI area to determine whether the medical center had appropriate signage and physical barriers to prevent unauthorized or

accidental access. Zones III and IV[2] were located within single locking doors in the Radiology Service's corridor. Because there were no additional physical barriers, we inspected the Radiology Service area to determine any security vulnerabilities. We noted an unlocked stairwell door that allowed unrestricted and potentially unobserved access to the area. We recommended that managers take immediate action to secure the door.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that patient MRI screenings are completed and documented in the medical record.

The VISN and Medical Center Directors concurred with the finding and recommendation. The MRI process has been modified so that patient screenings will be completed on the day of the examination. Screening forms will be signed by the technologist and the patient, and this documentation will be scanned into the Computerized Patient Record System (CPRS). Compliance with this process will be monitored. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires the MRI area to be secured.

The VISN and Medical Center Directors concurred with the finding and recommendation. The stairwell door has been permanently locked. The corrective action is acceptable, and we consider this recommendation closed.

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 JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

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

[2] Zone III includes the MRI technician's control room, and Zone IV houses the scanner. Both areas are to be restricted to only staff who have received specialized training or those patients who have been screened.

were performed by the receiving units. However, we identified the following areas that needed improvement.

Discharge Documentation. VHA policy[3] requires that providers include information regarding patients' medications, diets, activity levels, and recommended follow-up in discharge instructions. Additionally, the providers' discharge instructions must be consistent with the discharge summaries. We reviewed medical records for 15 discharges and found that in 7 (47 percent) of the records, patient discharge instructions were inconsistent with the discharge summaries.

Post-Discharge MH Care. VHA policy[4] has specific requirements for post-discharge MH care. MH providers are required to contact patients within 7 days of discharge. Patients must have a face-to-face MH evaluation within 14 days of discharge. We reviewed the medical records of three patients who were recently discharged from the locked acute MH unit. We found that one patient was referred to a fee basis MH program for follow-up. At the time of our review, the medical center had not received documentation from the fee basis provider regarding the patient's status.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that providers complete discharge documentation in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. An additional nursing discharge note will be created in CPRS that will pull in the standardized discharge medication list. Physicians will consult the new discharge note when documenting and dictating discharge summaries to ensure medication consistency at the time of discharge. Audits will be performed to ensure compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires timely post-discharge care

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

for patients discharged from the locked acute MH unit and documentation of that care, as required by VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The MH Division has established a follow-up team of social workers who will contact all inpatients within the 7-day timeframe. Follow-up appointments for face-to-face MH evaluations within 14 days of discharge will be scheduled with each patient's primary MH provider at the time of discharge. For patients referred to outside sources of care, face-to-face MH evaluations will be verified with the outside source and documented in the patient's medical record. The follow-up team will monitor compliance. 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 in the medical, surgical, locked acute MH, and SCI units and in the CLC.

The medical center had a designated Bar Code Medication Administration (BCMA) Program coordinator who had identified and addressed problems, and we found evidence of monitoring activities to improve BCMA procedures. We reviewed seven CLC patients' medical records to determine whether pharmacy staff had conducted monthly medication reviews. We found that the monthly reviews were completed for all seven patients. We identified one area that needed improvement.

Pain Medication Effectiveness Documentation. Local policy requires that nursing personnel assess and document the effectiveness of PRN pain medications within 4 hours after administration. We reviewed the medical records of 21 patients who received a total of 91 doses of PRN pain medications. Nursing personnel documented 73 (80 percent) of the 91 doses within the timeframe specified by local policy. Managers agreed that timely assessment and documentation of pain medication effectiveness are important and reported that they will monitor to ensure compliance.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing personnel

consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Staff education will be provided by pain resource professionals. Daily reports will be generated from BCMA within each 4-hour pain reassessment window. Program managers will review these reports to identify trends and opportunities for improvement. The BCMA Program coordinator will monitor compliance. 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 documents for several required components, including licensure, training, and competencies. Also, we reviewed the files of contracted/agency personnel who worked at the medical center within the past 12 months and identified one area that needed improvement.

Clinical Competence. Local policy requires that contracted/agency RNs complete unit-specific competencies before providing patient care. The medical center utilized two contracted/agency RNs who worked in clinical areas during the past 12 months. We found that one of the RNs had not completed clinical competencies for his/her assigned unit.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that nurse managers validate clinical competence of contracted/agency RNs prior to patient care assignments.

The VISN and Medical Center Directors concurred with the finding and recommendation. Guidelines were revised to emphasize the responsibility of nurse managers to validate contracted/agency RNs' clinical competencies. Compliance will be monitored by including contracted/agency RN records in the regularly scheduled audits conducted by the Human Resources Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Follow-Up on Cardiac Catheterization Laboratory Standards

As a follow-up to a recommendation from our prior CAP review, we re-evaluated whether practitioners who perform procedures in the CCL completed the informed consent process in accordance with VHA policy. VHA policy[5] requires that the informed consent includes the name and profession of the practitioner who has primary responsibility for the relevant aspect of the patient's care. It must also include the name and profession of any other individuals responsible for authorizing or performing the treatment or procedure under consideration. Additionally, the patient must be advised if another practitioner will need to be substituted for any of those named. We identified the following area that needed improvement.

Informed Consent. We reviewed the medical records of 10 patients who had procedures in the CCL during September and November 2009. In two patient records, we found discrepancies between the supervising practitioners listed on the informed consents and those listed in the procedure reports. This is a repeat finding from our prior CAP review. Additionally, in four records, we found that other practitioners were identified as operators in the CCL procedure reports; however, these practitioners were either different than or were in addition to those listed on the informed consents.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires the CCL informed consent process to be completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. All informed consents will be obtained on the day of the procedure by the physician performing the procedure and will reflect the physicians participating in the procedure. Before the patient enters the procedure room, laboratory staff and physicians will verify that the informed consent is correct. All CCL procedures will be monitored for compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[5] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.

Review Activity Without Recommendations

Physician Credentialing and Privileging

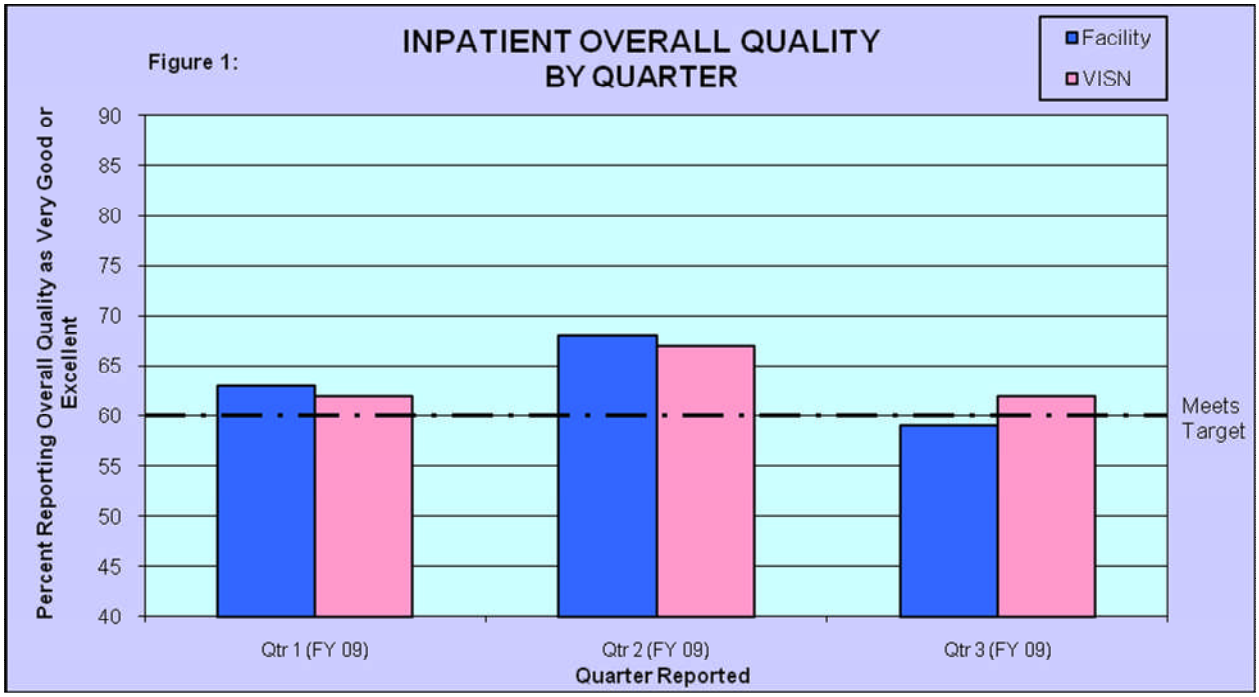
The purpose of this review was to determine whether VHA facilities have consistent processes for C&P physicians. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

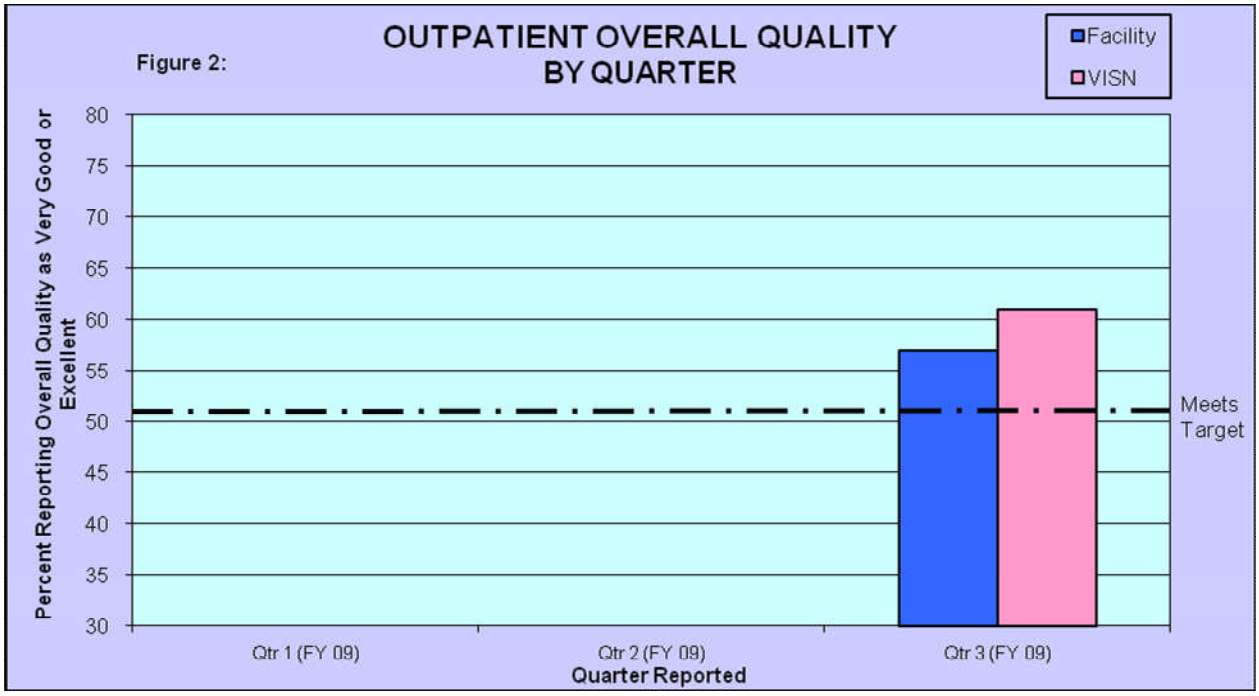
We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. 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 medical center's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[7] Target scores are noted on the graphs.

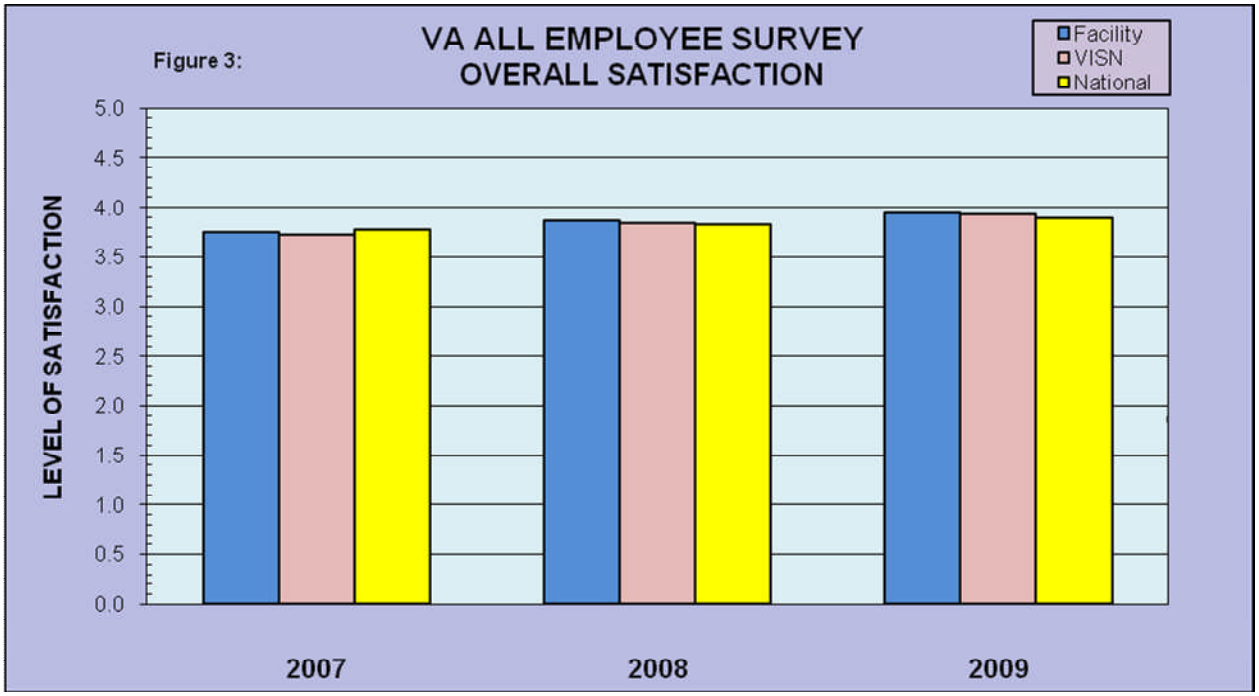
[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[7] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page shows the medical center's overall employee scores for 2007, 2008, and 2009. Because no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 18, 2010

From: Director, VA Great Lakes Health Care System (10N12)

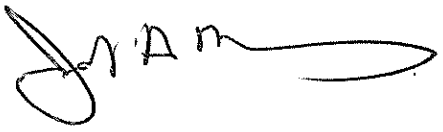
Subject: **Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (10B5)

1. I have reviewed and concur with the recommendations of the Office of Inspector General. The Clement J. Zablocki VA Medical Center is proceeding with the completion of the following attached action plan.

2. The professionalism and consultative manner demonstrated by your team during this review process was appreciated by all.



JEFFREY A. MURAWSKY, M.D.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 18, 2010

From: Director, Clement J. Zablocki VA Medical Center (695/00)

Subject: **Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin**

To: Director, VA Great Lakes Health Care System (10N12)

1. I concur with all of the findings and recommendations in the draft report.

2. The following corrective actions will be taken in response to the recommendations.

Robert H. Beller

ROBERT H. BELLER, FACHE

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 Medical Center Director requires that PRs that exceed 120 days have documented extensions, in accordance with VHA policy.

Concur

The timeline for completion of initial peer reviews has been decreased to 14 days. The frequency of PR Committee meetings has been changed from monthly to bimonthly as of November 2009. The days-to-committee timeframe is identified for each case discussed, and each case is tracked on every agenda. A formal mechanism has been developed to document requests for extensions over 120 days from the Medical Center Director. A standard notification letter has been developed. Thresholds for cases that have not been scheduled in timeframes for unexpected/unanticipated events that cause a scheduled review to exceed 120 days have been established. A bi-annual summary of cases that have been granted extensions will be submitted to the COS and Medical Center Director. Action is considered complete.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current CPR and/or ACLS certification and that a process is established to document, review, and track life support training.

Concur

The Medical Center Professional Services Memorandum IV-15 on Staff Training in Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) is under revision to define clinically active staff that will be required to have CPR and/or ACLS training. Target date for completion is March 1, 2010. An all-inclusive list of required non-LIP staff will be entered into the LMS with associated CPR and/or ACLS due dates to create a computerized tracking system. Target date for completion of this tracking system is April 1, 2010. LIPs will now be tracked through the Medical Staff Credentialing Office. Program managers for non-LIPs will receive monthly LMS reports from Employee Education for action.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the identified medication security, patient privacy, maintenance, and employee training concerns to be corrected.

Concur

Medication Security

In response to the 2006 OIG CAP review findings, the Medical Center had taken specific remedial action to ensure that medication carts were locked when unattended and to routinely monitor medication security through a number of activities including Individual (Patient) Tracer activity.

The Program Manager for the IV Team completed a review of cart security requirements with the eight IV Team members during the week of December 7, 2009. The Program Manager then instituted random monitoring of compliance with the requirements. Initial monitoring indicated 100 percent compliance. Beginning in February 2010, random monitoring of compliance will be documented with corrective action taken as necessary. All insulin in the ICU suite has been relocated to the locked medication room. Medication security will continue to be monitored during Individual (Patient) Tracer activity conducted by the Office of Quality Management and Safety.

Patient Privacy

In response to the 2006 OIG CAP review findings, the Medical Center had initiated ongoing proactive activities to address patient privacy including staff education, independent rounds by the Information Security Office, addition of the Information Security Officer to EOC Rounds, and Individual (Patient) Tracer activity. Patient information is shielded outside of the staff offices in outpatient care areas, and all clipboards were removed from handrails outside of patient rooms in inpatient areas.

The computer monitors on the telemetry unit had been located on the counter, facing outward into the corridor. On December 3, 2009, the Information Security Officer repositioned the monitors and keyboards to face into the nursing station, and privacy screens were ordered. Staff tried the repositioned equipment with positive results. The papers with personally identifiable patient information were noted on an IV Team cart. The Program Manager for the IV Team completed a review of patient information security requirements with the eight IV Team members during the week of December 7, 2009. The Program Manager then instituted random monitoring of compliance with the requirements. Initial monitoring indicated 100 percent compliance. Beginning in February 2010, random monitoring of compliance will be documented with corrective action taken

as necessary. For the video surveillance monitors in the ICU, corrective action was taken on December 3, 2009, to turn the monitors so they could not be viewed by anyone other than the nursing staff. For the video surveillance monitors on the locked acute MH unit, a plan was initiated to relocate the monitors and control involving coaxial and flat cable runs and re-hanging of the monitors. The target date for completion is April 30, 2010.

Maintenance

Overall, the Medical Center is in substantial compliance with monitoring the EOC on an ongoing basis through activities such as submission of work orders by appropriate program managers, EOC rounds, and Individual (Patient) Tracer activities. Deficiencies are tracked until completion. Most of the unsecured vinyl wall covering noted by the OIG Team have been reattached. The one remaining area where the vinyl wall covering was taped back was intended to allow for the installation of wider doors and frames for an electrical closet to meet NFPA codes for proper operating clearance for personnel. The work is part of an ongoing project scheduled for completion on March 28, 2010. All areas of non-slip strips that were not intact during the OIG CAP review were repaired and corrected by December 8, 2009. Facility Management surveyed the remainder of the medical center for similar repair needs. The survey was completed, and noted repairs were completed on December 18, 2009.

Employee Training

On the locked acute MH unit, environmental hazard identification training materials were obtained. Initial staff training will be completed no later than March 1, 2010. This training has been included in the new employee orientation program and as mandatory unit-specific annual training. Bloodborne pathogens training was completed with delinquent staff on January 1, 2010, and will be monitored to ensure 100 percent staff completion annually.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that patient MRI screenings are completed and documented in the medical record.

Concur

At the time of the OIG CAP review, the process in MRI had been modified so that MRI technologist patient screenings completed on the day of the examination are signed by the technologist and the patient, then are scanned into the CPRS. The Program Manager completed a review of random examinations performed in December 2009. The Program Manager will continue the random monthly monitors. Performance will be

considered satisfactory if 90 percent or greater compliance is obtained for 3 consecutive months.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires the MRI area to be secured.

Concur

On December 1, 2009, the Stairway 6 door was permanently locked. Egress via Stairway 6 is assured; however, no Radiology staff have key access. Of note, this stairway door was almost always, but not continuously locked prior to the 2009 OIG CAP review. Action is considered complete.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that providers complete discharge documentation in accordance with VHA policy.

Concur

A multidisciplinary work group formed through the Coordination of Care Council reviewed discharge process documentation in CPRS including discharge orders, nursing discharge notes, discharge instructions, and physician discharge summaries. It was noted that the discharge instructions did not always reflect the discharge summary. In addition, the medication lists provided to patients were inconsistent. There was an initiative already underway in the medical center at the time of the OIG CAP review to create a standardized medication list for discharge use. The proposed action to correct the deficiencies identified by the OIG Team will include reinforcement education on the content of the existing discharge orders and the need for discharge instructions to be consistent. A new, additional nursing discharge note will be created that will pull in the standardized discharge medication list. Physicians will be informed to consult the new nursing discharge note when documenting and dictating discharge summaries to ensure consistency with medications at the time of discharge. The creation of the new nursing discharge note will be completed no later than March 1, 2010. Education of the appropriate staff will be completed by April 1, 2010. An audit using a random sample of 10 discharges per month per unit will be completed by the nursing staff beginning in May 2010. Performance will be considered satisfactory if 90 percent or greater compliance with discharge documentation is obtained for 3 consecutive months.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires timely post-discharge care for patients discharged from the locked acute MH unit and documentation of that care, as required by VHA policy.

Concur

The MH Division has established a follow-up team of social workers who engage with all inpatients on the locked acute MH unit prior to discharge and follow-up after discharge. They will contact all inpatients within the 7 day timeframe including those who may be referred to outside sources of care (including fee basis MH programs). In addition, a psychologist conducts ongoing, scheduled aftercare groups that all patients, upon discharge, are encouraged to attend. Finally, follow-up appointments are scheduled at the time of discharge with each patient's primary MH provider for a face-to-face MH evaluation within 14 days of discharge. If patients are referred to outside sources of care (including fee basis MH programs), face-to-face MH evaluation will be verified with the outside source for compliance with established guidelines and documented in the patient's medical record by the social work follow-up team. The social work follow-up team will monitor the follow-up provided to 100 percent of patients for compliance with established timelines.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing personnel consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

Concur

Posters have been distributed to the nursing units focusing on the timeliness of pain reassessment and documentation of pain medication effectiveness. In the month of February 2010, unit pain resource professionals will complete education of the staff on their units on: unit population-specific pain reassessment guidelines, the 4-hour timeframe for documentation of pain medication effectiveness in BCMA, examples of inappropriate reassessment documentation, the specifics of documentation in BCMA, and problem times for documentation such as shift changes and patient transfers. Daily unit reports will be run from BCMA within each 4-hour pain reassessment window, for example, following each medication pass. Program managers will assign responsibility for these reports and will review them for trends and opportunities for improvement. At shift change, the status of PRN pain medication effectiveness documentation will be relayed to the oncoming shift. Beginning in March 2010, unit-specific reports will be run by the BCMA Coordinator for random periods of 3 consecutive days per month to assess compliance and will be shared with the program managers. Performance will be considered satisfactory if 90 percent or greater compliance with documentation is obtained for 3 consecutive months.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that nurse managers validate

clinical competence of contracted/agency RNs prior to patient care assignments.

Concur

Guidelines were revised to emphasize the responsibility of the nurse managers to validate contracted/agency RNs' clinical competencies before patient care is provided. Compliance will be monitored by including contracted/agency RN records (trifolders) in the regularly scheduled trifolder audits conducted by the Human Resources Committee.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires the CCL informed consent process to be completed in accordance with VHA policy.

Concur

In the CCL, all informed consents will be obtained on the day of the procedure by the physician performing the procedure. The consents will reflect the physicians participating in the procedure (staff and Fellows). Before the patient enters the procedure room, the laboratory staff and physicians will verify that the informed consent is correct. This will be additionally verified during the Time Out prior to any medications being given to the patient. All CCL procedures, diagnostic and interventional, will be monitored for 3 months (from February 4 through March 4, 2010) for compliance. The expectation for compliance is 100 percent.

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