Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01101-196

Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center Columbus, Ohio

June 16, 2011

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 crime awareness briefings 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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Glossary

AD	advanced directive
BMC	Behavioral Management Committee
C&P	credentialing and privileging
CAP	Combined Assessment Program
facility	Chalmers P. Wylie VA Ambulatory Care Center
FY	fiscal year
H&P	history and physical
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of April 11, 2011.

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

- Continuity of Care
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishments were preventing unnecessary inpatient admissions and readmissions and the receipt of the Gold Cornerstone Award for patient safety.

Recommendations: We made recommendations in the following five activities:

Coordination of Care: Provide patients with all components of written advance directive notification, document notification and screening in the medical record, and update local policy to include identification of staff responsible for providing advance directive notification.

Management of Workplace Violence: Ensure all violent incidents involving patient or employee victims are discussed at the Behavioral Management Committee.

Registered Nurse Competencies: Complete all competency validation documentation.

Quality Management: Ensure history and physical examinations are completed and documented in the required timeframe prior to procedures requiring moderate sedation.

Environment of Care: Complete N95 respirator fit testing, and monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Continuity of Care
- Coordination of Care
- Environment of Care
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through April 15, 2011, 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 facility (*Combined Assessment Program Review of the Chalmers P. Wylie*

Independent Outpatient Clinic, Columbus, Ohio, Report No. 08-01088-111, April 10, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 287 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.

Reported Accomplishments

Prevention of Unnecessary Admissions

The facility implemented a program to prevent unnecessary inpatient admissions and readmissions by improving case management, providing more services in-house, and expanding the hours of the urgent care clinic. During FY 2010, the facility prevented 46 readmissions for a cost savings of $506,000.

Gold Cornerstone Award

The facility received the Gold Cornerstone Award from the National Center for Patient Safety for their strong root cause analyses.[1]

Results

Review Activities With Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and ADs in accordance with applicable requirements.

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following areas that needed improvement.

AD Notification and Screening. VHA requires that patients receive written notification during the first VHA primary care appointment regarding their right to accept or refuse medical

[1] Root cause analysis is a tool or method used to determine why a problem happened and what can be done to prevent the problem from happening again.

treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[2] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that none of the records contained evidence of all components of written notification.

In addition, VHA requires that staff screen patients during the first VHA primary care appointment to determine whether they have an AD and document the screening in the medical record.[3] Facility staff did not document this screening for 10 of the 20 patients whose medical records we reviewed.

Facility Policy. VHA requires that the facility identify the staff responsible for providing AD notification.[4] The facility's policy did not designate the staff responsible for providing notification.

Recommendations

1. We recommended that processes be strengthened to ensure that all components of written AD notification are provided to patients and that AD notification and screening are documented in the medical record.

2. We recommended that facility policy be updated to include identification of the staff responsible for providing AD notification.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. We selected two assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following area that needed improvement.

Management of Incidents. Facility policy requires that all violent incidents involving patient or employee victims be discussed at the BMC. We reviewed BMC meeting minutes and did not find discussion of the two assault incidents.

[2] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[3] VHA Handbook 1004.02.
[4] VHA Handbook 1004.02.

Recommendation **3.** We recommended that processes be strengthened to ensure that all violent incidents involving patient or employee victims are discussed at the BMC.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. VHA requires that nursing personnel are competent to function in their assignments.[5] Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as surgery. Eight of the 12 RN competency folders had incomplete or missing validation documentation.

Recommendation **4.** We recommended that processes be strengthened to ensure that competency validation documentation is complete.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following area that needed improvement.

Moderate Sedation. VHA requires that providers document a complete H&P examination within 30 days prior to a procedure where moderate sedation will be used.[6] We reviewed the medical records of 10 patients who had selected procedures where moderate sedation was used and found that 2 patients did not have an H&P examination completed in the required timeframe.

Recommendation **5.** We recommended that processes be strengthened to ensure that H&P examinations are completed and

[5] VHA Manual M-2, *Clinical Affairs*, Part V, *Nursing Service*, Chapter 2, "Clinical Nursing Practice," July 13, 1989.
[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

documented in the required timeframe prior to procedures requiring moderate sedation.

Environment of Care

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the same day surgery/post-anesthesia care unit and the urgent care, mental health, spinal cord injury, physical medicine, primary care, and specialty care clinics. The facility maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Infection Control. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 20 employee training records and determined that four designated employees did not have the required annual fit testing.

Recommendation

6. We recommended that N95 respirator fit testing be completed and that compliance be monitored.

Review Activities Without Recommendations

Continuity of Care

The purpose of this review was to evaluate whether adequate continuity of care was provided for clinic patients hospitalized in the community.

To evaluate the adequacy of communication between facility primary care providers and community hospitals, we reviewed the medical records of 10 patients who were hospitalized in the community at VA expense. We determined that pertinent community hospital information was consistently conveyed to VA primary care providers. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared,

transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 10–13 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[7]		
Type of Organization	Ambulatory care medical center	
Complexity Level	3	
VISN	10	
Community Based Outpatient Clinics	Grove City, OH Marion, OH Newark, OH Zanesville, OH	
Veteran Population in Catchment Area	135,164	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	N/A	
• **CLC/Nursing Home Care Unit**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	The Ohio State University	
• **Number of Residents**	12.5	
	Current FY (through January 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$171	$166
• **Medical Care Expenditures**	$46	$166
Total Medical Care Full-Time Employee Equivalents	850.2	774
Workload:		
• **Number of Station Level Unique Patients**	26,200	34,132
• **Inpatient Days of Care:**		
o **Acute Care**	N/A	N/A
o **CLC/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges	N/A	N/A
Total Average Daily Census (including all bed types)	N/A	N/A
Cumulative Occupancy Rate (in percent)	N/A	N/A
Outpatient Visits	138,733	403,767

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Document Peer Review Committee discussions of recommendations for improvement in clinical practice, follow-up of provider responses to Level 2 or 3 peer reviews, and written feedback from supervisors.	The Peer Review Committee implemented a standardized format for minutes, agenda items, discussions with recommendations for improvement in clinical practice, and actions and/or follow-up items. This includes provider responses to Level 2 or 3 peer reviews, designation of the responsible party, and due dates for action items.	Y	N
2. Ensure that providers are only privileged to perform procedures that are within the capability of the clinic.	Core privileges have been revised to reflect the capability of the facility. Annual reviews are performed.	Y	N
3. Implement a process to monitor moderate sedation.	A process for monitoring compliance with defined protocols for moderate sedation and the use of reversal agents has been instituted. This data is on the Performance Improvement Committee agenda.	Y	N
Pharmacy Operations			
4. Conduct and document annual training for controlled substance inspectors.	All training is completed annually.	Y	N

VHA Satisfaction Surveys

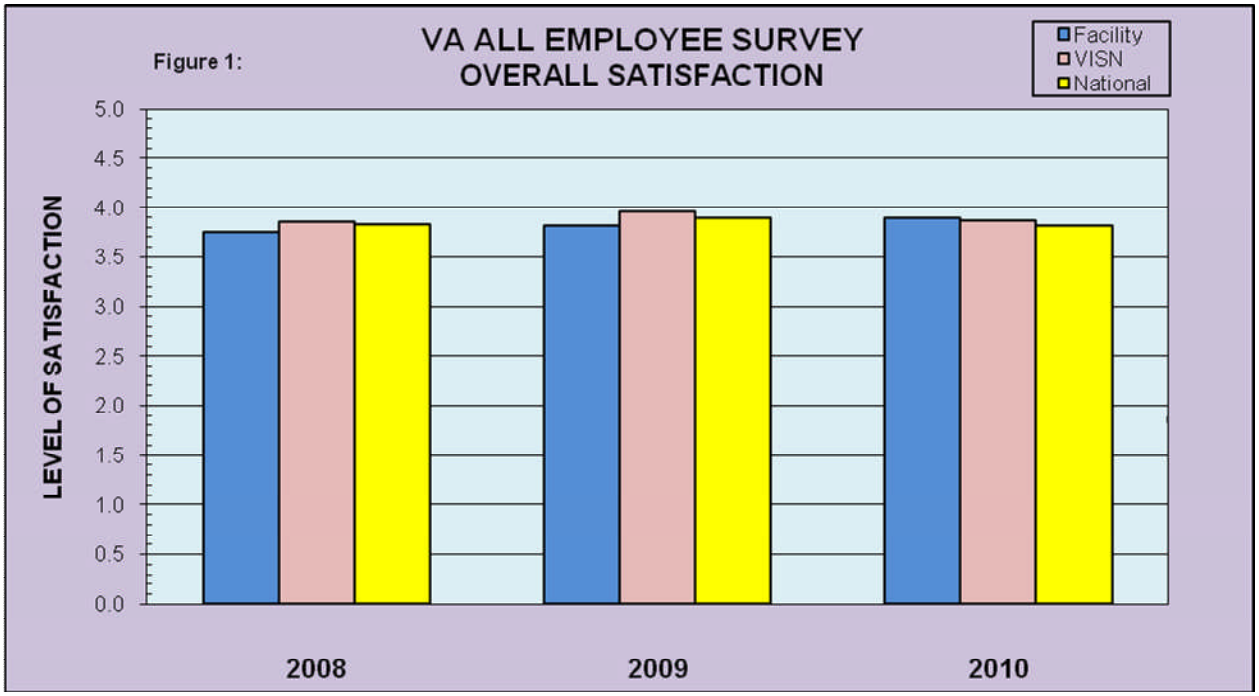
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	*	*	52.8	54.5	57.0	56.3
VISN	62.4	64.9	60.5	61.1	57.1	58.2	57.0	58.1
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

* This is an outpatient clinic, so there were no inpatient scores to report.

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. 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: May 25, 2011

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. I have reviewed the recommendations and concur with responses and action plans submitted by the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio.

2. If you have questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at (513) 247-4631.

(original signed by:)
Jack G. Hetrick, FACHE
Director, VA Healthcare System of Ohio (10N10)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2011

From: Director, Chalmers P. Wylie VA Ambulatory Care Center (757/00)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

To: Director, VA Healthcare System of Ohio (10N10)

1. Attached please find my comments and implementation plans in response to the recommendations identified in the OIG CAP Review conducted April 11–14, 2011, of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH. I concur with the findings and recommendations.

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

3. Should you have questions or require further information, please contact me at (614) 257-5450.

(original signed by:)
Lilian T. Thome, M.D.

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 processes be strengthened to ensure that all components of written AD notification are provided to patients and that AD notification and screening are documented in the medical record.

Concur

Target date for completion: 05/27/2011

The Computerized Patient Records System AD reminders were revised to provide documentation of AD actions and written information provided in the medical record. Clinical Reminder reactivation timelines have been adjusted to align with the AD policy for ongoing monitoring of AD status or changes requested.

Recommendation 2. We recommended that facility policy be updated to include identification of the staff responsible for providing AD notification.

Concur

Target date for completion: 06/15/2011

The AD policy has been revised to identify staff responsible for conducting AD notifications; the policy is currently being routed for approval. Additional plans to improve AD education include: regularly scheduled AD classes for Veterans; overhead announcements about classes; AD info blitz, info on the marquee, and quick-view monitors and AD day on 06/08/11.

Recommendation 3. We recommended that processes be strengthened to ensure that all violent incidents involving patient or employee victims are discussed at the BMC.

Concur

Target date for completion: 04/22/2011

The recommendation was addressed with the BMC and all cases of disruptive behavior will be reviewed by the committee and reported through the Environment of Care Committee monthly.

Recommendation 4. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

Concur

Target date for completion: 06/01/2011

Completed an audit of current RN/ Licensed Practical Nurse competency records. All current records are up to date with competency validation documentation. A standardized competency tool was developed for use with all RN and Licensed Practical Nurse competency validation. Monthly cross audits will be implemented and results reported to the Nurse Executive up to the Continuous Readiness Committee and the Performance Improvement Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that H&P examinations are completed and documented in the required timeframe prior to procedures requiring moderate sedation.

Concur

Target date for completion: 05/20/2011

Facility implemented a new process prior to the arrival of the OIG visit. The process included completing a new H&P at the time of the procedures requiring moderate sedation, if the H&P was greater than 30 days. Revision to the Pre-Moderate Sedation Template to include H&P, History of Present Illness, reason for the procedure and American Society of Anesthesiologists Score was completed and is scheduled for review and approval by the facility forms committee prior to implementation. Facility will conduct monthly random review of medical record audits to monitor new processes and sustain improvements. The analysis of the audit will be reported through the Performance Improvement Committee.

Recommendation 6. We recommended that N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: 06/01/2011

The Respiratory Protection Program was evaluated fully to ensure compliance with all requirements as defined in the Occupational Safety and Health Administration 1910.134 standard. The Fit Test process for the N95 respirators has been improved to ensure annual Fit Testing is completed for designated personnel. The Environment of Care Committee will track compliance of N95 Fit Test for designated employees on a quarterly frequency.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at 202-461-4720.
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