Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02077-282

Combined Assessment Program Review of the White River Junction VA Medical Center White River Junction, Vermont

September 15, 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

C&P	credentialing and privileging
CAP	Combined Assessment Program
COC	coordination of care
EN	enteral nutrition
EOC	environment of care
facility	White River Junction VA Medical Center
FY	fiscal year
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 White River Junction VA Medical Center, White River Junction, VT

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 July 11, 2011.

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

- Management of Workplace Violence
- Medication Management
- Quality Management
- Registered Nurse Competencies

The facility's reported accomplishments were the development of a tracking system for reusable medical equipment, the hospice chorus, and the Veterans Free Farmers' Market.

Recommendations: We made recommendations in the following four activities:

Coordination of Care: Ensure all components of written advance directive notification are provided to each patient, and document notification in the medical record. Update facility advance directive policy to identify the staff responsible for notification and to address the training requirements for staff involved in advance care planning discussions.

Physician Credentialing and Privileging: Ensure all privileges granted are appropriate for the clinical settings.

Enteral Nutrition Safety: Ensure that enteral nutrition documentation includes all required elements and that compliance is monitored.

Environment of Care: Ensure that employees with occupational exposure risk receive annual bloodborne pathogens training and that compliance is monitored.

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.

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:

- COC
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through June 30, 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 White River Junction VA*

Medical Center, White River Junction, Vermont, Report No. 08-02559-50, December 30, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 89 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

Reusable Medical Equipment Labeling Project

The Sterile Processing Department Team designed and implemented a Supply Processing and Distribution management package to streamline surgical instrument sterilization, tracking, and identification. The program creates repositories of information, such as an inventory of all instruments and instructions for their assembly, cleaning, and maintenance. It also generates productivity reports and instrument maintenance schedules and is easily expanded since data fields can be added as needed. The facility now has a complete inventory of all items and a systematic labeling system for each item.

Due to easy access to manufacturers' instructions and standard operating procedures through the system, cleaning and reprocessing have also been standardized. A bar code scanner logs all items into and out of the autoclave so that processing is automated and accurate. Additionally, sterilizer parameters were entered into the program to provide audio and visual feedback if an item is loaded incorrectly. Finally, each user has a unique sign-on for traceability and accountability.

Hospice Chorus

The chaplain established the hospice chorus in 2009. The a cappella group tries to provide comfort, relaxation, and support to dying veterans and their families during the last stage of life. The 29-member chorus includes employees, veterans, and other volunteers who give their time to those in need. Their repertoire includes songs from many cultures and traditions, including songs that address the journey of death and those that honor the joy of living. The music itself

communicates emotions and wordless images, connecting with the experiences and memories of those who hear it.

The Veterans Free Farmers' Market

The Veterans Free Farmers' Market is held weekly and offers outpatients free access to whole grain bread products, fruits, and vegetables. Volunteers at local markets and bakeries donate their excess produce and bread products. During harvest season, local farmers also contribute to the market. Additionally, access to informational pamphlets, recipes, and cookbooks is provided.

As the concept of the market grew and was adopted by other agencies, it became necessary to establish a non-profit organization within the community to oversee the program. During the past 5 years, more than 200 tons of wholesome food has been delivered to 60 drop off points throughout the region. The program received the 2011 Excellence in Government Award from the Federal Executive Association of Vermont.

Results

Review Activities With Recommendations

COC

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

We reviewed patients' medical records for evidence of advance directive notification, advance directive 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.

Advance Directive Notification. VHA requires that all patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an advance directive.[1] As part of notification, each patient must be informed that VA does not discriminate based on whether or not the patient has an advance directive. We reviewed the medical records of 20 patients and found that none of the

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

records contained evidence of all components of written notification.

Facility Policy. VHA requires that the facility identify the staff responsible for providing notification.[2] In addition, VHA requires that the facility address the training requirements for staff involved in advance care planning discussions with patients. The facility's policy did not designate the staff responsible for notification or address training requirements.

Recommendations

1. We recommended that processes be strengthened to ensure that all components of written advance directive notification are provided to each patient and that notification is documented in the medical record.

2. We recommended that facility policy be updated to identify the staff responsible for providing advance directive notification and to address the training requirements for staff involved in advance care planning discussions with patients.

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 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Setting-Specific Privileges. VHA requires that clinical privileges be setting specific.[3] The privileges for 5 of the 15 providers whose files and profiles we reviewed were not appropriate for the approved clinical settings. For example, providers were credentialed to perform partial mastectomies in a clinic or emergency department.

Recommendation

3. We recommended that all privileges granted be appropriate for the clinical settings.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where

[2] VHA Handbook 1004.02.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[4] We reviewed the medical records of 10 EN patients (5 inpatients and 5 outpatients) and found that records did consistently address required information. For example, three of the five inpatient records did not include sufficient documentation that staff checked gastric residuals.

Recommendation

4. We recommended that processes be strengthened to ensure that EN documentation includes all required elements and that compliance is monitored.

EOC

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 intensive care, the mental health, two medical/surgical, and the same day surgery/post-anesthesia care units. We also inspected the emergency department, the rehabilitation clinic, and the medical sub-specialty clinic. The facility maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule. We reviewed 25 employee training records and found that 14 employees did not have this training documented.

Recommendation

5. We recommended that employees with occupational exposure risk receive annual bloodborne pathogens training and that compliance is monitored.

Review Activities Without Recommendations

Management of Workplace Violence

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

[4] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. 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 same day surgery suite, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

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. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

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 assessments and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that actions were taken when deficiencies were identified. 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 14–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	General medical/surgical and psychiatric acute care facility	
Complexity Level	2	
VISN	1	
Community Based Outpatient Clinics	Colchester, VT Rutland,VT Bennington, VT Brattleboro, VT Newport, NH Littleton, NH	
Veteran Population in Catchment Area	103,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	60 acute care hospital beds	
Medical School Affiliation(s)	Dartmouth Medical School, Hanover, NH The University of Vermont, Burlington, VT	
• **Number of Residents**	237 – current academic year	
	Current FY (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$143.0	$153.2
• **Medical Care Expenditures**	$74.3	$153.2
Total Medical Care Full-Time Employee Equivalents	834.86	802.11
Workload:		
• **Number of Station Level Unique Patients**	19,496	23,585
• **Inpatient Days of Care:**		
o **Acute Care**	3,653	14,090
Hospital Discharges	1,195	2,338
Total Average Daily Census (including all bed types)	42.0	38.6
Cumulative Occupancy Rate (in percent)	66.6	64.3
Outpatient Visits	118,080	217,000

[5] 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. Collect, analyze, and use provider performance data during reprivileging.	The Professional Standards Board developed a process for establishing service- and specialty-specific Focused and Ongoing Professional Practice Evaluation documentation. Minutes of the Clinical Executive Board reflect the use of this data during reprivileging.	Y	N
2. Grant privileges that are consistent with providers' practices.	More specific privileging systems were approved and are currently in use by the Professional Standards Board.	Y	N
3. Ensure that Peer Review Committee minutes reflect that recommended action items are implemented and that the committee reports quarterly to the Clinical Executive Board.	Beginning with quarter 1 of FY 2009, a quarterly report of Peer Review Committee activity has been submitted to Clinical Executive Board.	Y	N
4. Ensure that clinical managers monitor corrective actions and implement a plan to monitor anticoagulation therapy.	A plan to monitor corrective actions of all open root cause analyses is in place, and the new tool is being used. Completion of action items will be evaluated and documented monthly. The anticoagulation directive has been updated to reflect VHA standards and has been implemented. Adverse drug events and medication errors are reported through the patient safety incident reporting system.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Ensure that clinicians discuss adverse events with patients and document the discussions in the medical records.	Ongoing education was implemented for clinicians on adverse event documentation. Facility-wide training was completed December 31, 2008. The Risk Manager monitors and tracks disclosure documentation.	Y	N
Medication Management			
6. Document pain reassessments within appropriate timeframes.	Documentation of the effectiveness and timeliness of as needed pain medication is monitored at the unit and service level weekly. Nurse managers identify outliers and re-educate staff in documentation requirements.	Y	N
7. Ensure that nurses scan all patients' wristbands prior to medication administration.	The results of 5 months of observation of staff who administer medications indicate 100 percent compliance with the Bar Code Medication Administration Policy, including scanning of patient wristbands.	Y	N
Emergency/Urgent Care Clinic			
8. Ensure that emergency department RNs demonstrate required competencies annually and that compliance is documented.	Completion of the competency checklist was added to Nursing's Proficiency Tracking database; compliance is monitored by the Associate Director of Nursing for Patient Care Services. Episodes of non-compliance are reported to the Associate Nurse Executive.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
COC			
9. Ensure that discharge instructions are consistent with discharge summaries and that patients receive written discharge instructions.	Each clinical service has addressed the issue of consistency by reinforcing this requirement with attending physicians and house staff. The Chief of Staff's office developed an initial observational process to assess consistency between discharge instructions and discharge summaries, which is to be done quarterly. Patients receive a copy of the discharge instructions with telephone follow-up.	Y	N
Pharmacy Operations			
10. Maintain appropriate medication storage temperatures, and minimize security and infection control risks in the inpatient pharmacy.	Facilities Management Service removed the air conditioner unit and cleaned the air ducts. Medication storage temperatures are monitored during environmental rounds.	Y	N

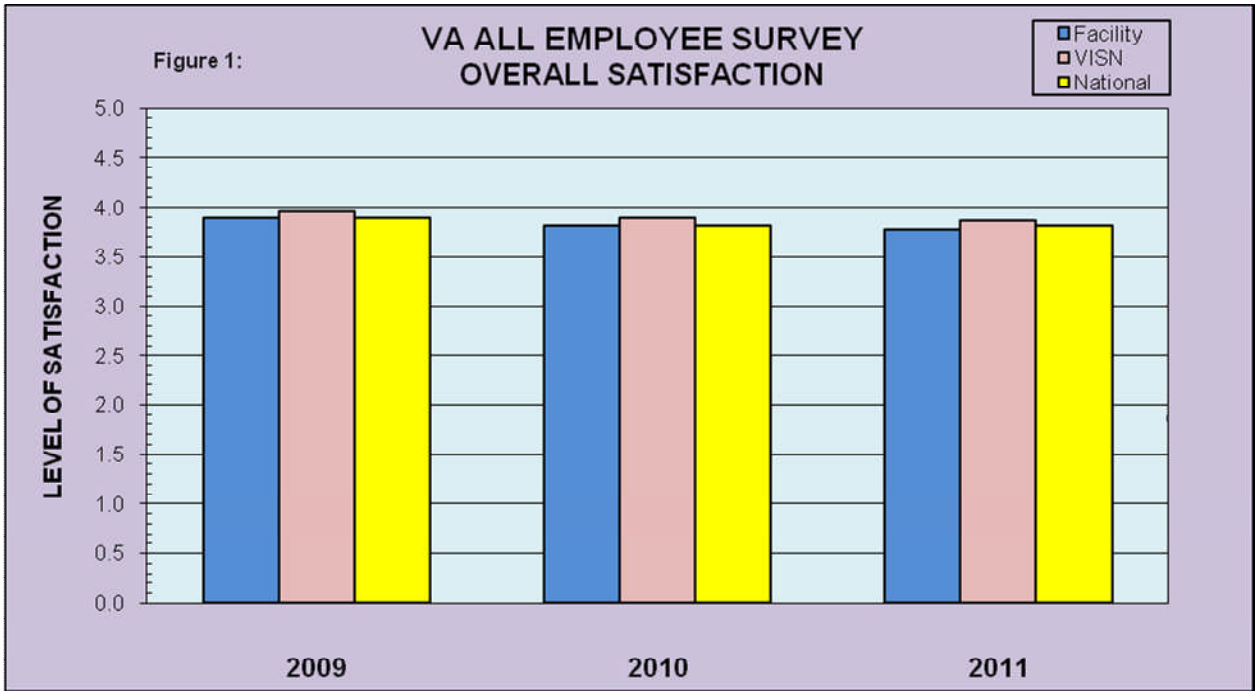
VHA Satisfaction Surveys

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 quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3 and 4 Combined	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1 and 2 Combined	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	73.0	58.3	60.6	64.5	69.2	68.2
VISN	63.5	62.7	61.6	65.2	62.3	60.6
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[6] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	12.71	10.02	14.52	21.05	19.48	16.14
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[6] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2011

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

To: Director, Bedford Office of Healthcare Inspections (54BN)

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

1. Attached is the reply to the CAP Review of the White River Junction VA Medical Center, White River Junction, VT issued August 5, 2011.

2. If you have any questions regarding the information or require additional information, please contact Denise Lord at (781) 687-4850.

(original signed by Henry Stankiewicz for:)
Michael Mayo-Smith, MD
Network Director VISN 1

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 24, 2011

From: Director, White River Junction VA Medical Center (405/00)

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

To: Director, VA New England Healthcare System (10N1)

1. We concur with the findings and recommendations presented in the VA White River Junction OIG report of August 2011. Facility comments included in this final report comprise a brief implementation plan and target dates for each recommendation.

2. We appreciated and benefited from the thorough review of the operation systems and processes, as well as from the consultative and helpful nature of the team members' interactions with staff at all levels of our organization. The goal to provide excellent quality of care and services remains our primary mission; this OIG survey validated our quality of care and now provides additional opportunities for process improvement.

3. Please contact me with additional questions or concerns regarding this report.

Thank you,

Robert M. Walton

Robert M. Walton

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 advance directive notification are provided to each patient and that notification is documented in the medical record.

Concur – The membership of the facility Integrated Ethics Committee has been enhanced and now includes staff closest to the process of Advance Care Planning as outlined in VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives* (Published July 2009). Members are in the process of redesigning the facility policy and ensuring it includes all necessary elements. The final policy will specifically focus on individual staff responsibility for Advance Directives at the discipline level, will now include a process map/algorithm, and required medical record documentation triggers. A key element in our deployment of the new policy will be staff education. In addition, we will be revising the in and outpatient handbooks to include patient education, what to expect from our facility Advance Directive process, and information regarding who to contact when there are questions or concerns.

Target date for completion: October 1, 2011

Recommendation 2. We recommended that facility policy be updated to identify the staff responsible for providing advance directive notification and to address the training requirements for staff involved in advance care planning discussions with patients.

Concur – In addition to the action plan noted above which includes policy redesign with a process map/algorithm for easy identification of staff specific responsibilities, a rigorous training activity(s) will be a key element of deployment. The training activity will be complete by December 1, 2011.

Target date for completion: December 1, 2011

Recommendation 3. We recommended that all privileges granted be appropriate for the clinical settings.

Concur – Action for this recommendation includes the redesign of the facility level privilege request and approval template. As part of the VA national credentialing and privileging files scanning initiative, each provider's file will be updated to include the revised template. Revisions to these providers' files will reflect an administrative action as current privileges are accurate and appropriate.

Target date for completion: December 31, 2011

Recommendation 4. We recommended that processes be strengthened to ensure that EN documentation includes all required elements and that compliance is monitored.

Concur – A multidisciplinary team made up of all staff who participate in the process of enteral nutrition has been formed and charged with redesigning the facility policy to include all elements of VA guidelines and facility specific monitoring. Quarterly monitoring of specific quality indicators will be conducted and presented to the Executive Committee of the Medical Staff beginning 2nd Qtr FY12. Reporting will be quarterly until such time as the medical staff deems less frequent reporting is appropriate.

Target date for completion: October 1, 2011

Recommendation 5. We recommended that employees with occupational exposure risk receive annual bloodborne pathogens training and that compliance is monitored.

Concur – As of August 15, 98% of all employees having completed this training have their training documented appropriately. The remaining training will be completed and evidence of training appropriately documented by the action target date noted here. In addition, all blood borne pathogen training records are now entered into the employee TMS learning system.

Target date for completion: October 1, 2011

OIG Contact and Staff Acknowledgments

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