Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01291-241

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

August 12, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Clement J. Zablocki VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of May 12, 2014.

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

- Environment of Care
- Medication Management
- Coordination of Care

The facility's reported accomplishments were implementation of a standardized medication reconciliation program and the facility's Pathology and Laboratory Medicine Service Product Line.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure the Surgical Work Group consistently meets monthly. Require that the Blood Usage Review Committee member from Medicine Service attends meetings.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient, and screen patients for difficulty swallowing prior to oral intake. Ensure employees involved in assessing and treating stroke patients receive the training required by the facility.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to residents' care plans. Modify restorative nursing interventions as needed, and document the modifications. Ensure hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy. Require that employees who perform restorative nursing services receive range of motion training.

Magnetic Resonance Imaging Safety: Ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan. Require that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–25, for the full text of the Directors' comments.) 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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FYs 2011–2013 and FY 2014 through May 14, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin,* Report No. 11-04567-179, May 21, 2012).

During this review, we presented crime awareness briefings for 95 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 1,111 responded. We shared summarized results with facility managers.

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

Pharmacist Admission Medication Reconciliation Program

In February 2014, the pharmacy implemented a standardized admission medication reconciliation program. During the first 6 weeks, pharmacists completed 333 interventions and made 902 recommendations to providers during patient admissions. As a result of this new program, the number of medication discrepancies detected by pharmacists during medication reconciliation at a patient's discharge has decreased significantly.

Pathology and Laboratory Medicine Service Product Line

The facility's Pathology and Laboratory Medicine Service Product Line serves as 1 of 2 core laboratories for VISN 12, performing special chemistry and infectious disease testing and microbiology and mycology testing for the Northern Tier. In addition, the facility's laboratory performs all of the mycobacteriology testing for VISN 12. In August 2013, the product line achieved complete VISN standardization of critical laboratory values.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met twice over the past 6 months.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Medicine Service did not attend the past four quarterly meetings.
NA	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Surgical Work Group consistently meet monthly.

2. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Medicine Service attends meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the emergency department, the CLC, the intensive care unit, the inpatient MH unit, the oncology unit, the surgical unit, SDS, the PACU, and the eye clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 27 employee training records (12 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 19 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 36 randomly selected patients who experienced stroke symptoms, and 15 employee training records (5 emergency department, 5 intensive care unit, and 5 inpatient unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, urgent care, one critical care unit, and four acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Eight EHRs (22 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Nine EHRs (25 percent) did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
	Clinicians provided printed stroke education to patients upon discharge.	
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Five employees had not completed the web-based training required by the facility.
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

3. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

5. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 20 EHRs of residents (10 residents receiving restorative nursing services and 10 residents not receiving restorative nursing services but candidates for services). We also observed 5 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• None of the 10 applicable EHRs contained documentation that facility staff completed restorative nursing services according to residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• None of the three applicable EHRs contained evidence that facility staff documented that interventions were modified to promote the residents' accomplishment of goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
X	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	• None of the three EHRs of residents who were discharged from one of the therapies reflected hand-off communication.
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Four employee training records did not contain evidence of completed training for range of motion.
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to residents' care plans and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that staff modify restorative nursing interventions as needed and document the modifications and that compliance be monitored.

8. We recommended that process be strengthened to ensure that hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy to ensure that restorative nursing services occur.

9. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training for range of motion.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 46 employees (30 randomly selected Level 1 ancillary staff and 16 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Twenty-eight of 29 applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Six Level 1 ancillary staff (20 percent) did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

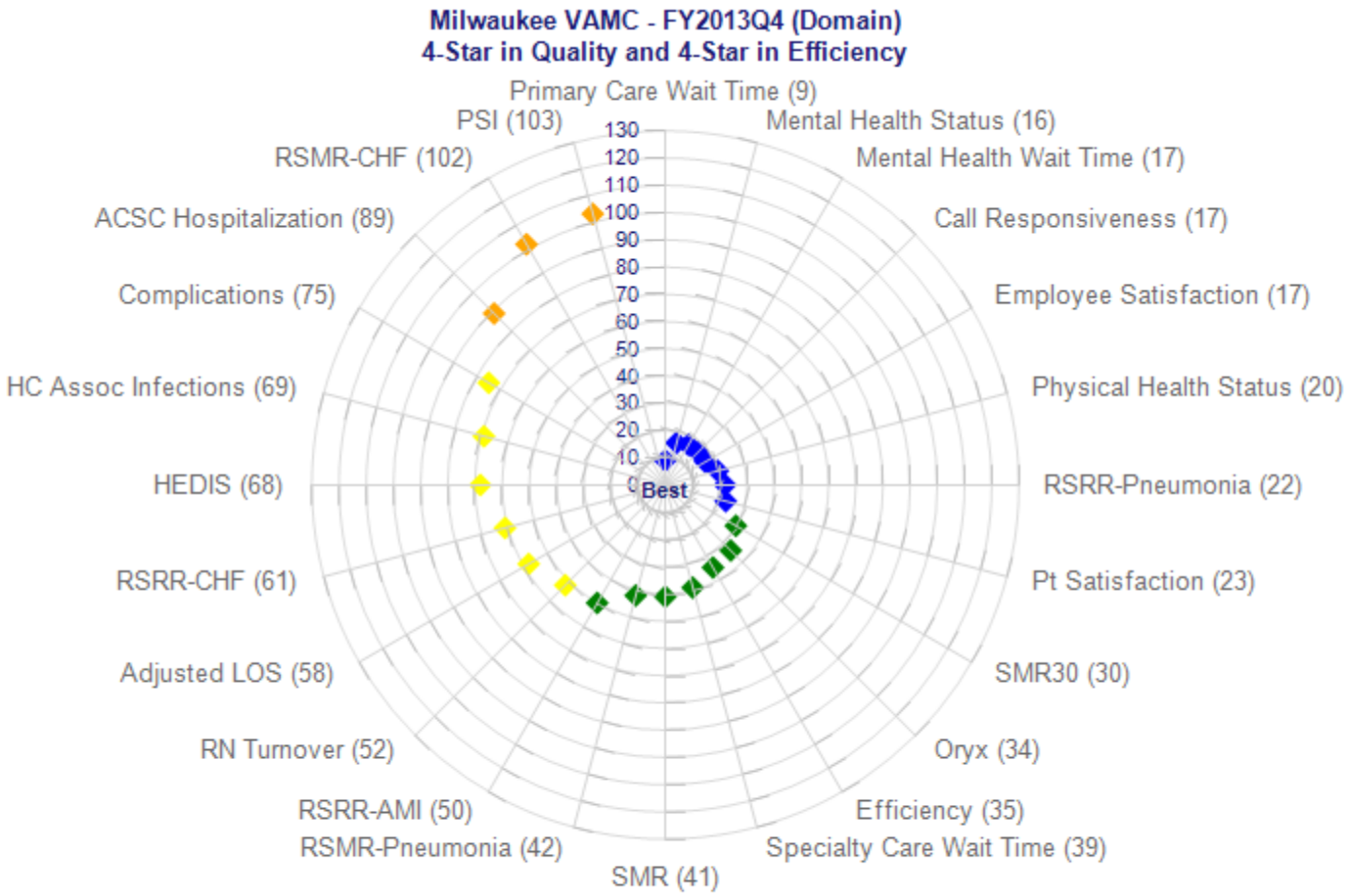
10. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to magnetic resonance imaging and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Facility Profile (Milwaukee/695) FY 2014 through May 2014[1]	
Type of Organization	Primary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$546.2
Number of:	
• **Unique Patients**	55,263
• **Outpatient Visits**	491,306
• **Unique Employees**[2]	3,129
Type and Number of Operating Beds (as of April 2014):	
• **Hospital**	196
• **CLC**	113
• **MH**	205
Average Daily Census:	
• **Hospital**	130
• **CLC**	83
• **MH**	133
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Appleton/695BY Union Grove/695GA Cleveland/695GC Green Bay/695GD
VISN Number	12

[1] All data is for FY 2014 through May 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

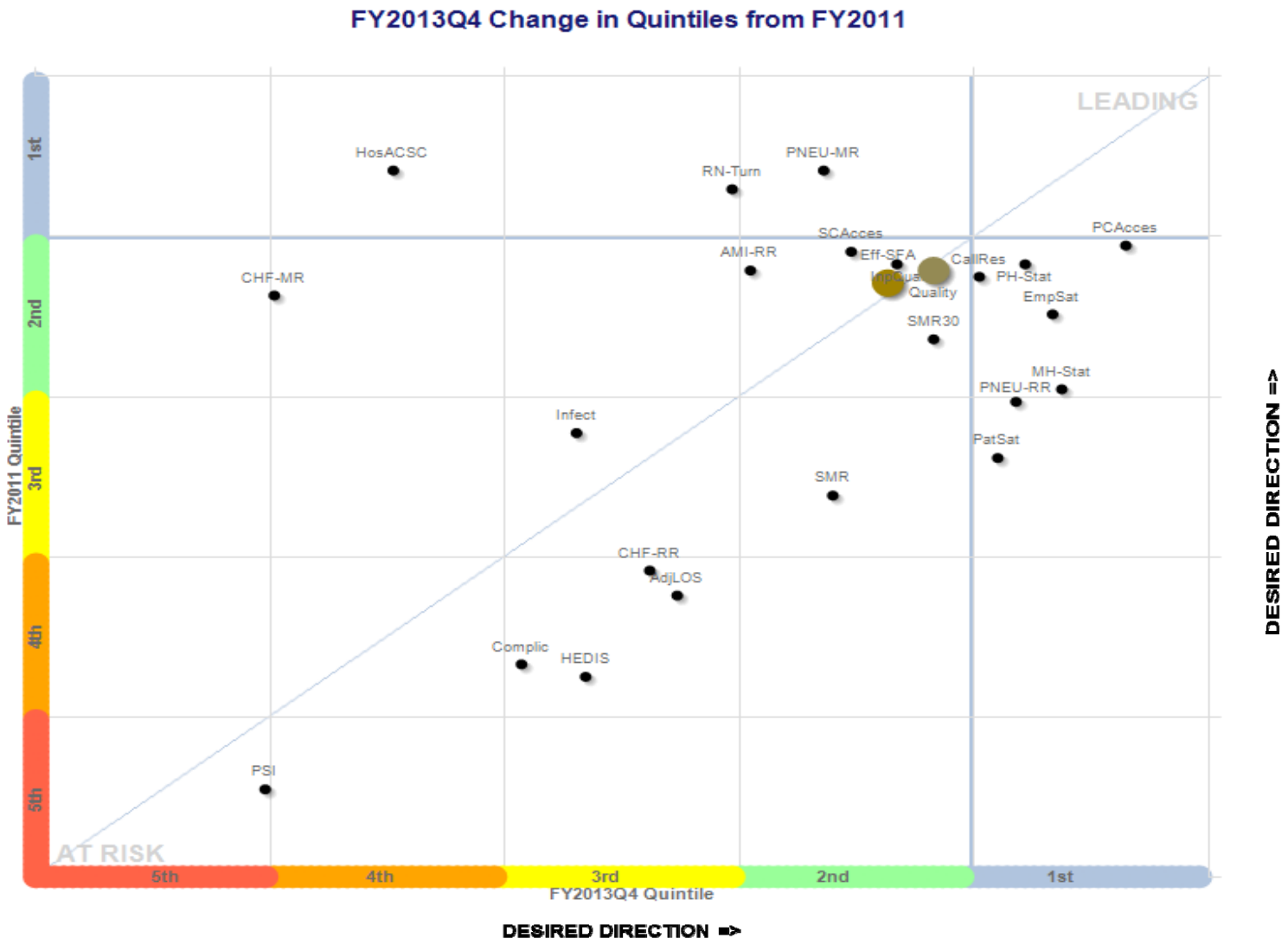
Strategic Analytics for Improvement and Learning (SAIL)[3]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 14, 2014

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

Subject: **CAP Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI**

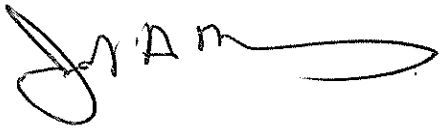
To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached please find the CAP Review response to the draft report from the Clement J. Zablocki VA Medical Center, Milwaukee, WI review.

2. I have reviewed the completed response.

3. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at the Milwaukee VAMC.



Jeffrey A. Murawsky, MD, FACP

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 11, 2014

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

Subject: **CAP Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI**

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

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report on the Milwaukee CAP Review.

2. If you have any questions or wish to discuss this report, please contact me at (414) 384-2000, Extension 41025.

Robert H. Beller

Robert H. Beller, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Surgical Work Group consistently meet monthly.

Concur

Target Date for Completion: July 31, 2014

Facility Response: The Surgical Work Group began monthly meetings in February 2014. Meeting minutes will be monitored to ensure the Work Group meets consistently.

Recommendation 2. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Medicine Service attends meetings.

Concur

Target Date for Completion: July 31, 2014

Facility Response: Medicine has been represented at the Blood Utilization Council since the First Quarter, FY14 meeting on March 3, 2014. Meeting minutes will be monitored to ensure attendance from Medicine Service.

Recommendation 3. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: Requirements for completion and documentation of the National Institutes of Health (NIH) Stroke Scale were reiterated at the Stroke Work Group meeting in May 2014 to the representatives of the Emergency Department Nurses and Physicians, Intensive Care Unit Nursing Staff and the Hospitalists. Audit processes were modified and initiated in June 2014 to include monthly medical record monitoring of NIH Stroke Scale documentation. Compliance will be considered satisfactory if the compliance rate is 90 percent or greater, however, the cohort of applicable patients exhibiting stroke symptoms is small.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Date for Completion: October 31, 2014

Facility Response: Requirements for completion and documentation of screening for swallowing difficulty prior to oral intake were reiterated at the Stroke Work Group meeting in May 2014 to the representatives of the Emergency Department Nurses and Physicians, Intensive Care Unit Nursing Staff and the Hospitalists. Audit processes were modified and initiated in June 2014 to include monthly medical record monitoring of documentation for difficulty swallowing prior to oral intake. Compliance will be considered satisfactory if the compliance rate is 90 percent or greater, however, the cohort of applicable patients exhibiting stroke symptoms is small.

Recommendation 5. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: Web-based training for Emergency Department Registered Nurses and Providers, Intensive Care Unit Registered Nurses, Hospitalists, Medical Intensive Care Unit Attending Physicians and Acute Care Registered Nurses will be required every two (2) years. The required training requirements are assigned in the Talent Management System (TMS). TMS reports will be generated and shared with Program Managers on a monthly basis to track and ensure training completion for required staff. Compliance will be considered satisfactory if the compliance rate is 90 percent or greater.

Recommendation 6. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to residents' care plans and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: Education for direct care nursing staff was developed by the Nurse Educator, Program Managers, and Clinical Nurse Specialists and completed March 19, 2014. The education occurred via staff meetings, email communications and enduring materials which focused on following the established plan of care and documenting the restorative nursing care delivered. Staff education of CLC direct care nursing staff was recorded in the Talent Management System and greater than 90 percent compliance was achieved on July 2, 2014. Community Living Center staff

will develop an audit tool in July 2014 to monitor documentation for all residents receiving restorative care services in accordance with care plans. Compliance will be considered satisfactory if 90 percent or greater of restorative care services are completed and documented.

Recommendation 7. We recommended that processes be strengthened to ensure that staff modify restorative nursing interventions as needed and document the modifications and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: The Restorative Coordination Committee met to develop a systematic approach for modification, documentation, and monitoring of restorative care interventions. Community Living Center Registered Nurses will be educated on the process to modify and document restorative care interventions by July 31, 2014. Community Living Center neighborhood staff will develop an audit tool in July 2014 to monitor documentation of modification of residents' restorative care services. Compliance will be considered satisfactory if 90 percent or greater of modified restorative care services are completed and documented.

Recommendation 8. We recommended that process be strengthened to ensure that hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy to ensure that restorative nursing services occur.

Concur

Target Date for Completion: October 31, 2014

Facility Response: A process for hand-off communication and staff education for PM&R and direct care nursing staff was completed on April 10, 2014. Community Living Center neighborhood staff will develop an audit tool in July 2014 to document that handoff communication between Physical Medicine and Rehabilitation and Nursing Services is consistently completed when residents are discharged from rehabilitation services and begin restorative nursing services. Monthly auditing will being in July 2014 on all residents discharged from therapy. Compliance will be considered satisfactory if 90 percent or greater of hand off communications are completed and documented and restorative nursing services are initiated.

Recommendation 9. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training for range of motion.

Concur

Target Date for Completion: July 31, 2014

Facility Response: Range Of Motion education was developed by the Nurse Educator on March 19, 2014. Education and return demonstration assessment was completed and recorded in the Talent Management System. As of July 2, 2014, 87 percent of applicable employees have been trained and demonstrated competence. All staff that perform restorative nursing services will complete ROM education by July 31, 2014. Compliance will be considered satisfactory if 90 percent of staff have been trained and demonstrate compliance.

Recommendation 10. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: Contraindications will be recorded in the electronic health record via VISTA Imaging Capture/Display and a determination of risk will be noted. Beginning in July 2014, monthly audits will be conducted to review compliance with documentation to determine a compliance rate. Results will be reported to the MRI Safety Committee. Compliance will be considered satisfactory if the compliance rate is 90 percent or greater.

Recommendation 11. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target Date for Completion: October 31, 2014

Facility Response: Appropriate personnel will be assigned to TMS Magnetic Resonance Imaging Safety Training 9696 or other appropriate site-specific training by July 31, 2014. Personnel will be assigned Level-specific training based on the recommendations in the American College of Radiology Guidelines. A review of the personnel assigned will be audited for accuracy by August 15, 2014. Monthly TMS reports will be generated for Program Managers to track education compliance. Training results will be reported to the MRI Safety Committee. Compliance will be considered satisfactory if the compliance rate is 90 percent or greater.

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Endnotes

[a] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
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- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
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[e] The references used for this topic were:
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- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

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- Various requirements of The Joint Commission.

[g] References used for this topic included:

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