Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02078-38

Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center Walla Walla, Washington

November 24, 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
CS	controlled substances
ECMS	Executive Committee of the Medical Staff
EHR	electronic health record
EOC	environment of care
facility	Jonathan M. Wainwright Memorial VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MM	medication management
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
RRTP	residential rehabilitation treatment program
RRU	residential rehabilitation unit
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 August 18, 2014.

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

- Medication Management – Controlled Substances Inspection Program

The facility's reported accomplishment was its Life Goals Project, a veteran-centered approach to individualized care based on what matters to the veteran.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure the Quality Management Board meets at least quarterly. Require the Peer Review Committee to consistently submit quarterly summary reports to the Executive Committee of the Medical Staff. Initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Ensure the Executive Committee of the Medical Staff discusses and documents its approval of the use of another facility's providers for teledermatology services.

Environment of Care: Ensure all specialty clinic employees receive annual bloodborne pathogens training. Require that eye clinic exam/procedure room sinks have foot controls, long-blade handles, or automatic no touch sensors.

Continuity of Care: Ensure medical information from non-VA hospitalizations is consistently scanned into the electronic health record. Require that clinicians document acknowledgement of their patients' recent non-VA hospitalizations.

Management of Test Results: Notify all patients of abnormal Pap smear results/values within the expected timeframe, and document notification in the electronic health record. Notify all patients of normal lab results/values and radiology results within the expected timeframe, and document notification in the electronic health record.

Suicide Prevention Program: Ensure patients and/or their families receive a copy of the safety plan.

Management of Workplace Violence: Ensure all employees receive Level I training, and document training in employee training records.

Mental Health Residential Rehabilitation Treatment Program: Ensure residential rehabilitation unit employees perform and document daily inspections for unsecured medications. Establish a process to alert residential rehabilitation unit employees when

alarmed doors that are not considered main points of entry are opened from the inside, and test the process regularly.

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 19–25 for the full text of the Directors' comments.) We consider recommendations 4 and 5 closed. We will follow up on the planned actions for the open recommendations 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 eight activities:

- QM
- EOC
- MM – CS Inspection Program
- Continuity of Care
- Management of Test Results
- Suicide Prevention Program
- Management of Workplace Violence
- MH RRTP

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 FY 2012, FY 2013, and FY 2014 through August 20, 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 Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington,* Report No. 12-01875-249, August 14, 2012). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 63 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 197 responded. We shared summarized results with the facility Director.

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 Accomplishment

Life Goals Project

VHA's Primary Care Program Office recognized Primary Care Service's Patient Aligned Care Teams from the Richland Community Based Outpatient Clinic as having a best practice for the Life Goals Project. The project has since been incorporated system wide and received Bright Spot recognition from VHA's National Center for Health Promotion and Disease Prevention.

The Life Goals Project uses a veteran-centered approach to find out what matters to the veteran, establish a relationship with the veteran and/or his or her family, and build care around the veteran's desires. The team coaches the veteran through goal setting and strategies to accomplish those goals. The team tracks the goals in the EHR and uses them as the roadmap for individualized care.

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
X	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.	• Although local policy requires the QM Board to meet at least quarterly, the board only met once from March through August 2014.
X	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.	Twelve months of ECMS meeting minutes reviewed: • Only one quarterly PRC summary report was documented as received by the ECMS. This was a repeat finding from the previous CAP review.
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Six profiles reviewed: • None of the Focused Professional Practice Evaluations were initiated.
X	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.	Twelve months of ECMS meeting minutes reviewed: • There was no evidence that the ECMS had approved the use of another facility's providers for teledermatology services.

NM	Areas Reviewed (continued)	Findings
NA	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.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	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.	
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
NA	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
NA	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.	
	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 Quality Management Board meet at least quarterly.

2. We recommended that the Peer Review Committee consistently submit quarterly summary reports to the Executive Committee of the Medical Staff.

3. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluations for newly hired licensed independent practitioners are initiated.

4. We recommended that the Executive Committee of the Medical Staff discuss and document its approval of the use of another facility's providers for teledermatology services.

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 audiology, primary care, specialty care, and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed five specialty clinic area employee training records. 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 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.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Occupational Safety and Health Administration regulations reviewed: • None of the 5 specialty clinic employees received the required annual bloodborne pathogens training during the past 12 months.
	Areas Reviewed for SDS and the PACU	
NA	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
NA	Fire safety requirements in SDS and on the PACU were met.	
NA	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA	Infection prevention requirements in SDS and on the PACU were met.	
NA	Medication safety and security requirements in SDS and on the PACU were met.	
NA	Auditory privacy requirements in SDS and on the PACU were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
NA	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
X	Environmental safety requirements in the eye clinic were met.	• Two of six exam/procedure rooms did not have a sink with foot controls, long-blade handles, or automatic no touch sensors.
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
NA	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.	

Recommendations

5. We recommended that processes be strengthened to ensure that all specialty clinic employees receive annual bloodborne pathogens training.

6. We recommended that eye clinic exam/procedure room sinks have foot controls, long-blade handles, or automatic no touch sensors.

MM – CS Inspection Program

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[c]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of both CS Coordinators and 12 CS inspectors and inspection documentation from 2 CS areas and the pharmacy. 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
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.[d] Such information is essential to coordination of care and optimal patient outcomes.

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community from February 1, 2013, to February 1, 2014. 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
X	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.	• Medical information from three patients' non-VA hospitalizations was not scanned into the EHRs.
X	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.	• Three EHRs contained no clinician documentation about the recent hospitalization.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that processes be strengthened to ensure that the medical information from non-VA hospitalizations is consistently scanned into the electronic health record and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians document acknowledgement of their patients' recent non-VA hospitalizations.

Management of Test Results

The purpose of this review was to evaluate whether the facility complied with selected requirements for managing test results.[e]

We reviewed relevant policies and procedures and the EHRs of 26 patients who had critical laboratory, critical radiology, or abnormal Pap smear test results/values in FY 2014 (10 for laboratory, 8 for radiology, and 8 for Pap smear). In addition, we reviewed the EHRs of 30 patients who had normal laboratory, radiology, or Pap smear results/values. We also 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 had a written policy or guideline that addressed the management of critical/abnormal test results/values, and compliance was monitored.	
	Providers were notified of critical/abnormal test results/values by appropriate staff within the expected timeframe.	
X	Patients were notified of critical/abnormal test results/values within the expected timeframe and by the approved method of communication.	• Two of the eight EHRs of patients with abnormal Pap smear results/values did not contain documentation of patient notification within the expected timeframe.
	Follow-up actions were taken in response to critical/abnormal test results/values.	
X	Patients were notified of normal test results/values within the expected timeframe.	• Three of the 10 EHRs of patients with normal lab results/values and 3 of the 10 EHRs of patients with normal radiology results did not contain documentation of patient notification.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that processes be strengthened to ensure that all patients are notified of abnormal Pap smear results/values within the expected timeframe and that notification is documented in the electronic health record and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that all patients are notified of normal lab results/values and radiology results within the expected timeframe and that notification is documented in the electronic health record.

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[f]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide and the training records of 15 new employees. The table below shows the areas reviewed for this topic. The area 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 had a full-time Suicide Prevention Coordinator and a plan for back-up.	
	The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.	
	The facility provided suicide prevention training to new staff and community organizations.	
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.	
	The facility had a process to follow up on patients who missed MH appointments.	
	Patients had documented safety plans that specifically addressed suicidality.	
	Patients and/or their families participated in safety plan development.	
	Safety plans contained all required elements.	
X	There was documented evidence that the patients and/or their families received a copy of the safety plan.	• Seventeen patients' EHRs (57 percent) did not contain documentation that the patients and/or their families received a copy of the plan.
	Patient Record Flags were placed for high-risk patients.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

11. We recommended that processes be strengthened to ensure that patients and/or their families receive a copy of the safety plan and that compliance be monitored.

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility managed violent incidents.[9]

We reviewed relevant documents, 1 Report of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 18-month period January 2013–July 2014, and 15 training records of employees who worked in areas at low, moderate, or high risk for violence. Additionally, we conversed with key employees. The table below shows the areas reviewed for this topic. The area 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 had policies, procedures, or guidelines on preventing and managing violent behavior.	
	The facility conducted an annual Workplace Behavioral Risk Assessment.	
	The facility had an Employee Threat Assessment Team, a Disruptive Behavior Committee/Board, and a prevention and management of disruptive behavior program disruptive behavior reporting and tracking system.	
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.	
X	The facility had an employee training plan that addressed the security issues of awareness, preparedness, precautions, and police assistance, and employees received the required training.	• Four employee training records did not contain documentation of the required Level 1 training.
	Selected incidents were managed appropriately according to the facility's policies.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that processes be strengthened to ensure that all employees receive Level 1 training and that the training be documented in employee training records.

MH RRTP

The purpose of this review was to determine whether the facility's Psychosocial RRTP and Substance Abuse RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the RRU housing the two programs, 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 residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe MM and contraband detection.	
	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	
X	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	• Daily RRU inspections for unsecured medications were not documented.
	Written agreements acknowledging resident responsibility for medication security were in place.	
X	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• The alarm for the doors that were not considered main points of entry was silent, and the alert transmitted to an area outside the RRU. There was no established procedure to notify RRU employees.
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NM	Areas Reviewed (continued)	Findings
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

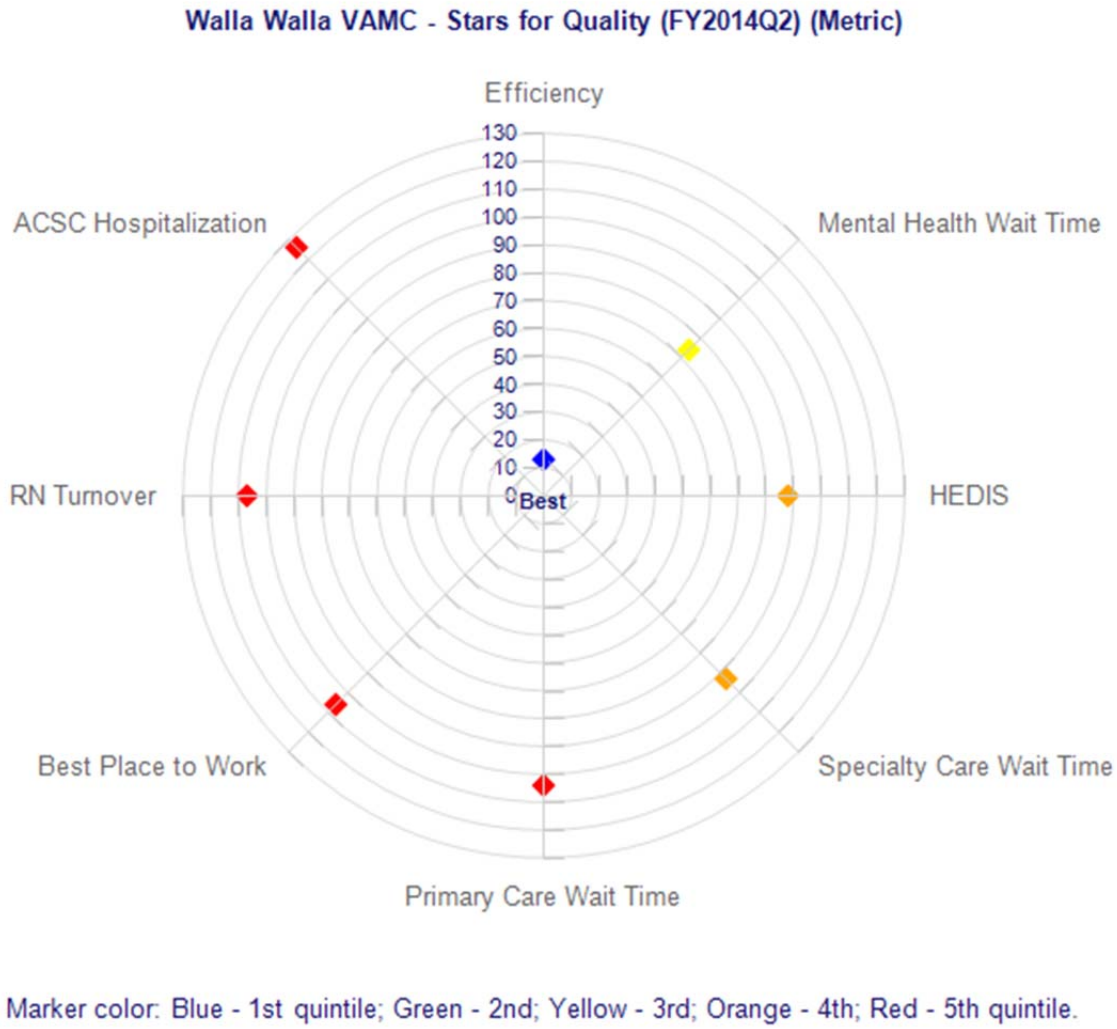
13. We recommended that processes be strengthened to ensure that residential rehabilitation unit employees perform and document daily inspections for unsecured medications and that compliance be monitored.

14. We recommended that a process be in place to alert residential rehabilitation unit employees when alarmed doors that are not considered main points of entry are opened from the inside and that the process be tested regularly.

Facility Profile (Walla Walla/687) FY 2014 through August 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$87.6
Number of:	
• **Unique Patients**	17,811
• **Outpatient Visits**	173,256
• **Unique Employees**[2]	375
Type and Number of Operating Beds (July 2014):	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	36
Average Daily Census (July 2014):	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	29
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Richland/687GA Lewiston/687GB La Grande/687GC Yakima/687HA
VISN Number	20

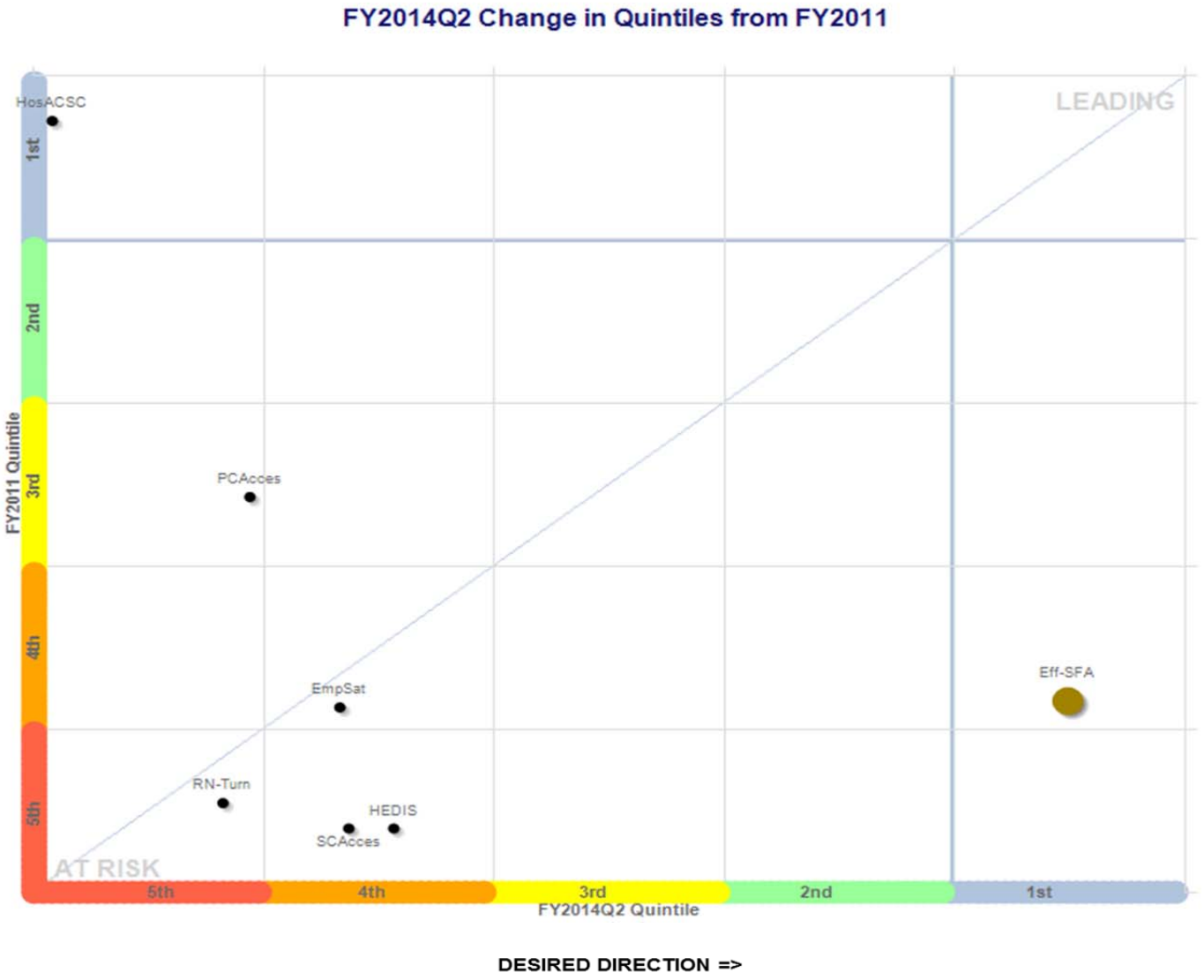
[1] All data is for FY 2014 through August 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 17, 2014

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to respond to the proposed recommendations from the Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 16, 2014

From: Director, Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA (687/00)

Subject: **CAP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

To: Director, Northwest Network (10N20)

1. I concur with the findings/recommendations presented in this Combined Assessment Program review of the Jonathan M. Wainwright Memorial VA Medical Center. Actions taken as a result of these findings are attached.

2. I would like to note that the IG Team Leader and team that conducted the audit did so in a very professional and collegial manner that made the site visit productive and educational for our staff involved.

3. If you have any questions regarding the content of this report, please contact me at (509) 527-3450.

Brian Westfield, MSN

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 Quality Management Board meet at least quarterly.

Concur

Target date for completion: 31 Aug, 2015

Facility response:

The Quality Management oversight board will meet quarterly for four/four quarters. The facility will monitor improvement for one year through the Executive Leadership Council. To date we have held meetings on August 12, September 19 and October 14 for 100% compliance thus far.

Recommendation 2. We recommended that the Peer Review Committee consistently submit quarterly summary reports to the Executive Committee of the Medical Staff.

Concur

Target date for completion: 31 Aug, 2015

Facility response:

Peer Review Committee (PRC) Chair will report to Executive Committee of the Medical Staff (ECMS) quarterly. The ECMS Chair has established the format/content of the required report. The PRC chair reported on September 10 and October 10. In addition, the year-end summary was completed and reported to ECMS on October 10. The ECMS Chair will monitor for one year through the ECMS minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluations for newly hired licensed independent practitioners are initiated.

Concur

Target date for completion: 30 Apr, 2015

Facility response:

The Credentialing and Privileging (C/P) Coordinator will initiate Focused Professional Practice Evaluation (FPPE) for newly hired Licensed Independent Practitioners (LIPs).

The C/P Coordinator has been moved from the COS office to the Office of Quality, Safety & Value (QSV). The Director, QSV will evaluate the work load and staffing requirements needed to ensure all C/P requirements are met.

The facility will monitor through Credentialing and Privileging Committee (CPC) until proven sustained improvement for three months

Recommendation 4. We recommended that the Executive Committee of the Medical Staff discuss and document its approval of the use of another facility's providers for teledermatology services.

Concur

Target date for completion: 31 Oct, 2014

Facility response:

Completed. On October 8, ECMS reviewed/approved 100% (5/5) of facility's providers that will be providing service to WWVAMC through teledermatology.

Recommendation 5. We recommended that processes be strengthened to ensure that all specialty clinic employees receive annual bloodborne pathogens training.

Concur

Target date for completion: 30 Sep, 2014

Facility response:

Completed. All current five Specialty Clinic Staff (SPS) have completed the bloodborne pathogen (BBP) training. They had received the general risk/hazards training that included BBP as a portion of the curriculum. They have now completed the specific BBP training as well.

Recommendation 6. We recommended that eye clinic exam/procedure room sinks have foot controls, long-blade handles, or automatic no touch sensors.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

Currently we have one room with standard single lever handle, room 120. Facility will change to correct handle type via work order (with a compliant type); work order for room 104 placed with high priority. The Chief, Optometry will follow up on work order in 10 business days to ensure completion.

Recommendation 7. We recommended that processes be strengthened to ensure that the medical information from non-VA hospitalizations is consistently scanned into the electronic health record and that compliance be monitored.

Concur

Target date for completion: 01 Mar, 2015

Facility response:

Non-VA Medical Care (NVMC) will scan all Insurance Billing Forms and attachments into Fee Basis Claims Software (FBCS) program for payment processing. Health Information Management System (HIMS) will scan all records from NVMC into Computerized Patient Records System (CPRS) using appropriate titles. Any records unable to be scanned due to a lack of authenticated signature will be processed in accordance with VA Handbook 1907.01, Draft HA Scanning Policy and Fact Sheet Non-VA Care.

The Chief of NVMC will monitor until 90% compliance for three months.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians document acknowledgement of their patients' recent non-VA hospitalizations.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

Chief of Staff (COS) briefed medical staff that the provider must document the acknowledgement. Associate Director of Patient Care Services (Nurse Executive) briefed nurses that it must be the provider to document. The Chief of Staff will monitor monthly until 90% compliance for three months.

Recommendation 9. We recommended that processes be strengthened to ensure that all patients are notified of abnormal Pap smear results/values within the expected timeframe and that notification is documented in the electronic health record and that compliance be monitored.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

COS briefed medical staff and general medical staff that a letter is not sufficient; provider must adhere to protocol timeline and will need to document results into

Computerized Patient Records System (CPRS). The Women's Health Coordinator will monitor monthly until 100% compliance for three months.

In addition, an HC-FMEA was initiated to review the results reporting process.

Recommendation 10. We recommended that processes be strengthened to ensure that all patients are notified of normal lab results/values and radiology results within the expected timeframe and that notification is documented in the electronic health record.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

Chief of Staff (COS) briefed medical staff and general medical staff that a letter to the patient is not sufficient since it may not reach the patient within the required timeframe; provider must adhere to protocol timeline and will need to document results into Computerized Patient Records System (CPRS). COS will monitor until 90% compliance for three months.

Recommendation 11. We recommended that processes be strengthened to ensure that patients and/or their families receive a copy of the safety plan and that compliance be monitored.

Concur

Target date for completion: 01 Mar, 2015

Facility response:

A check box was added to documentation to acknowledge that the safety plan was given to the Veteran. Safety plans will be monitored monthly to ensure documentation that a copy was provided to Veterans and/or their families. The Supervisor of Recovery and Mental Health Specialty Services will monitor until 100% of plans are documented for three months.

Recommendation 12. We recommended that processes be strengthened to ensure that all employees receive Level 1 training and that the training be documented in employee training records.

Concur

Target date for completion: 9 Oct, 2014

Facility response:

Completed. Four/four of the staff have received the training.

Recommendation 13. We recommended that processes be strengthened to ensure that residential rehabilitation unit employees perform and document daily inspections for unsecured medications and that compliance be monitored.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

The code MU (for meds unsecured) was added to the Inpatient Security Checklist Form. Staff were instructed by MHRTTP Nurse Mgr to monitor for unsecured medication when making unit rounds. Discussion of the process is on the agenda for the 20 Oct 14 staff meeting. During the initial Medication Reconciliation conducted by an RN, residents are instructed regarding securing medications.

The Nurse Mgr will monitor documentation until 100% compliance for three months.

Recommendation 14. We recommended that a process be in place to alert residential rehabilitation unit employees when alarmed doors that are not considered main points of entry are opened from the inside and that the process be tested regularly.

Concur

Target date for completion: 31 Jan, 2015

Facility response:

On October 8, 2014, the unit manager was informed that the contractor who installed the system has been notified, and is expected to return to the facility to resolve this problem by relocating the alarm panel. The doors did have alarms installed which were designed to transmit information to the Medical Administrative Assistant's (MAA) office who is on call 24/7. The Nurse Mgr will meet with Facility Mgr to determine what the regular testing process will be once relocated. Not fixed to date.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Mary Noel Rees, MPA, Team Leader Carol Lukasewicz, RN, BSN Sarah Mainzer, RN, JD Sami O'Neill, MA Susan Tostenrude, MS Robert Sproull, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Jeff Joppie, BS Marc Lainhart, BS Nathan McClafferty, MS Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- 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.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- 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:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[d] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

[e] References used for this topic were:
- VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
- VHA Directive 1106, *Pathology and Laboratory Medicine Service*, April 5, 2013.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- Various requirements of the Joint Commission.

[f] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of the Joint Commission.

[g] References used for this topic were:

- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.

[h] References used for this topic were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.