Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02083-06

Combined Assessment Program Review of VA Butler Healthcare Butler, Pennsylvania

October 19, 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
CLC	community living center
EN	enteral nutrition
EOC	environment of care
facility	VA Butler Healthcare
FY	fiscal year
JC	Joint Commission
OIG	Office of Inspector General
PI	performance improvement
QM	quality management
RN	registered nurse
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of VA Butler Healthcare, Butler, PA

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 August 8, 2011.

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

- Coordination of Care
- Enteral Nutrition Safety
- Management of Workplace Violence
- Physician Credentialing and Privileging
- Quality Management

The facility's reported accomplishments were the performance improvement reporting form and dashboards, which improved management and visualization of performance progress, and the Capital Asset Planning/Construction Project Team, which significantly improved project management and funding allocation.

Recommendations: We made recommendations in the following two activities:

Environment of Care: Ensure the facility designates community living center employees on all shifts to be fit tested and implements a process to periodically review this list and add employees as necessary to maintain appropriate numbers per shift.

Registered Nurse Competencies: Establish a policy or process to identify a defined list of unit/position-specific competencies. Require competency validation documentation to be complete and current. Ensure core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency. Require managers to specify the qualifications required for individuals who perform competency assessment and validation.

Comments

The Veterans Integrated Service Network and Acting 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 seven activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through August 8, 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 VA Butler Healthcare, Butler, Pennsylvania,* Report No. 09-00517-97,

March 16, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 135 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

PI Reporting Form

The facility's PI reporting form and dashboards have been standardized to display PI measurement progress at a glance using color codes of green (for met or exceeded compliance) and red (for non-compliance). Displays include target performance over a 3-year timeframe and a process owner. When a PI measure falls below target, the process owner completes a PI reporting form to address data analysis, conclusions, action plans, responsibility, implementation dates, and the evaluation of actions taken.

Capital Asset Planning/ Construction Project Team

The Capital Asset Planning/Construction Project Team was formed in 2007 to systematically and strategically address capital improvements to and maintenance of the facility's 1940's vintage campus. The team meets weekly and consists of the Associate Director; an interior designer; the Chiefs of Engineering, Contracting, and Environmental Management Services; and other staff. With this focused approach, the team has improved project management, communication, activity coordination, and allocation of the $12 million budget.

Results

Review Activities With Recommendations

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 and whether the facility's domiciliary RRTPs complied with selected Mental Health RRTP requirements.

We inspected the audiology, ophthalmology, podiatry, and dental departments and both CLC units. We also inspected

the Domiciliary Substance Abuse RRTP and Domiciliary Care Homeless Veteran RRTP units. The facility maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Infection Control. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees be fit tested annually. We reviewed 15 employee training records and determined that all employees had the required annual fit testing.

The CLC designated four to six employees per shift to be fit tested for the N95 respirator. However, on the list provided to the OIG, 5 of the 16 designated CLC employees no longer worked on that unit. Additionally, there was no process or plan to reevaluate the need to designate different employees and ensure that fit tested employees were available on all tours of duty to care for CLC residents in airborne isolation.

Recommendation

1. We recommended that the facility designate CLC employees on all shifts to be fit tested and implement a process to periodically review this list and add employees as necessary to maintain appropriate numbers per shift.

RN Competencies

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

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

Facility Competency Validation Process. The JC requires that clinical staff are deemed competent to perform their job responsibilities. A competency validation policy or process is required for staff who provide patient care, treatment, or services. Assessment and validation of competencies should be done when the RN is hired and then at least every 3 years. The facility did not have a defined and effective RN competency validation policy or process. Although core competencies were identified, unit/position-specific competencies were not consistently identified. In addition, documentation of completed competencies was not consistently available.

Competency Validation Documentation. The JC requires that nursing personnel are competent to function in their assignments. Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as a CLC. We found that 8 of the 12 competency folders we reviewed had incomplete or missing validation documentation or outdated forms.

Competency Validation Methods. The JC requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. We found that for some competencies, validation methods were not specified for the skill being assessed and validated.

Competency Validation by Qualified Individuals. The JC requires that competency is assessed and validated by an individual with the appropriate education, experience, or knowledge related to the skills being reviewed. Facility processes did not specify the qualifications required for individuals who perform competency assessment and validation.

Recommendations

2. We recommended that a policy or process be established to identify a defined list of unit/position-specific competencies.

3. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

4. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

5. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

Review Activities Without Recommendations

Coordination of Care

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 and the facility's advance care planning policy and determined that the facility

generally met VHA requirements. We made no recommendations.

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' electronic medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Management of Workplace Violence

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

We reviewed the facility's policy and training plan. 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.

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

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.

Comments

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

Facility Profile[1]		
Type of Organization	Independent outpatient clinic	
Complexity Level	3	
VISN	4	
Community Based Outpatient Clinics	Cranberry Township, PA Ford City, PA Foxburg, PA Hermitage, PA New Castle, PA	
Veteran Population in Catchment Area	39,148	
Type and Number of Total Operating Beds:		
• **Hospital, including Psychosocial RRTP**	66	
• **CLC/Nursing Home Care Unit**	60	
• **Other**	0	
Medical School Affiliation(s)	none	
• **Number of Residents**	0	
	Current FY (through May 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$92	$96
• **Medical Care Expenditures**	$67	$70
Total Medical Care Full-Time Employee Equivalents	593	585
Workload:		
• **Number of Station Level Unique Patients**	15,331	18,486
• **Inpatient Days of Care:**		
o **Acute Care**	N/A	N/A
o **CLC/Nursing Home Care Unit**	6,480	19,220
Discharges	118	225
Total Average Daily Census (including all bed types)	68	112
Cumulative Occupancy Rate (in percent)	41.7	69
Outpatient Visits	87,350	141,620

[1] 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**
EOC			
1. Ensure that the Contracting Officer's Technical Representative conducts daily inspections of construction sites and that contractor oversight is documented.	Daily oversight of construction sites was monitored successfully. The monitor was discontinued due to 100 percent compliance, but the Contracting Officer's Technical Representatives continue to monitor.	Y	N
2. Ensure that fire extinguisher signage complies with VA policy.	New signage was purchased and installed.	Y	N
Coordination of Care			
3. Ensure that discharge instructions are consistent with discharge summaries.	Discharge summaries being congruent with discharge instructions was monitored successfully with 100 percent compliance noted.	Y	N
QM			
4. Ensure that contract physicians' privileges do not extend beyond the length of the contract and that contracts are appropriately renewed.	There is a main list of providers with contract dates indicated, which is used by the C&P Coordinator for tracking purposes. Each contract indicates the renewal dates for each site. The corresponding Medical Executive Committee minutes include the provider privileged at each site.	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.

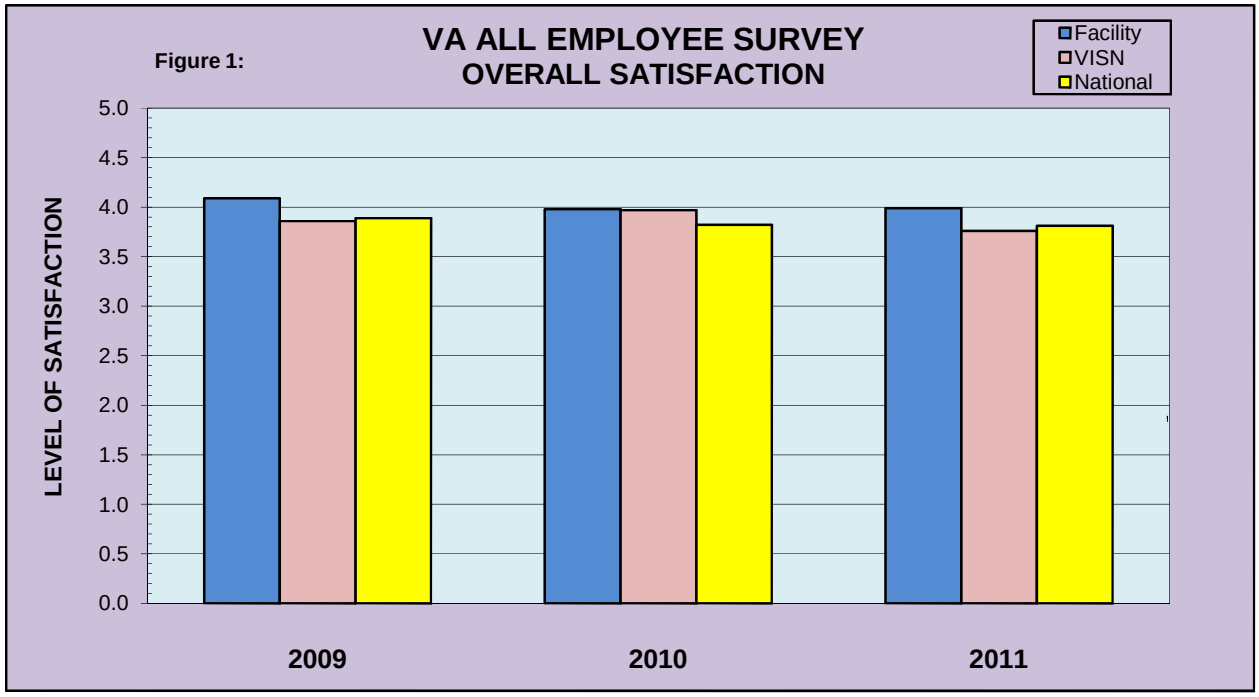
Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	51.9	63.7	*	73.2	67.4
VISN	64.2	60.1	61.8	63.6	63.9	59.2
VHA	64.1	54.8	54.4	63.9	55.9	55.3

* The facility does not provide inpatient care.

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.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 5, 2011

From: Director, VISN 4, (10N4)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

I have reviewed the submitted corrective actions and concur with the findings and recommendations.

(original signed by:)
MICHAEL E. MORELAND, FACHE

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2011

From: Acting Director, VA Butler Healthcare (529/00)

Subject: **CAP Review of VA Butler Healthcare, Butler, PA**

To: Director, VISN 4 (10N4)

Attached is our response to the CAP Review draft report from the survey conducted at VA Butler Healthcare the week of August 8, 2011.

There is concurrence with all recommendations and corrective actions have been initiated. A follow up folder page and supporting documents have been uploaded to the Butler VA Healthcare SharePoint.

Thank you for the opportunity to participate in this review.

(original signed by:)
SEAN H. NELSON

Acting Medical Center Director

Comments to Office of Inspector General's Report

The following Acting Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the facility designate CLC employees on all shifts to be fit tested and implement a process to periodically review this list and add employees as necessary to maintain appropriate numbers per shift.

Concur. The Environmental Protection Specialist is responsible for the Respiratory Protection Program. The nurse managers will maintain a minimum of four staff members per shift from the Community Living Center to be included in the Respiratory Protection Program. The nurse managers will provide updates to the EPS when a respirator-qualified employee is permanently removed from the CLC. A replacement employee will be evaluated, trained, and fit tested within 30 days of assignment to the CLC. The Environmental Protection Specialist or designee will conduct quarterly audits to evaluate compliance. The results of this audit will be reported to the Environment of Care Committee for any required action/recommendation.

N=Number of CLC staff who are fit tested

D=Total number of CLC staff who require fit testing

Target date for completion: December 1, 2011

Recommendation 2. We recommended that a policy or process be established to identify a defined list of unit/position-specific competencies.

Concur. The process for the identification of a defined list of unit/position specific competencies is that each nurse manager/supervisor is required to annually submit position-specific competencies to the Nurse Executive Council for approval. The approved list will be documented in the minutes of the Nurse Executive Council. A list of defined core competencies for all RN staff has been developed and outlined in the draft policy, "Evaluating Competency of Nursing Staff."

See VA Butler Healthcare OIG/CAP share point site for draft policy.

Target Date for completion: November 1, 2011.

Recommendation 3. We recommended that processes be strengthened to ensure that competency validation documentation is complete and current.

Concur. Each nurse manager/supervisor is responsible for ensuring that the competency validation documentation is complete and specifies the method of verification, the date of validation, and the signature of the valuator and employee. This

is specified in the draft policy, "Evaluating Competency of Nursing Staff." The Associate Director for Patient Care Services will monitor five RN competencies each quarter to assure that documentation is complete and current. The results of this audit will be reported to the Nurse Executive Committee.

See Butler Healthcare OIG/CAP share point site for draft policy.

N=Number of competencies that are complete/current

D=Total number of competencies reviewed

Target date for completion: November 1, 2011.

Recommendation 4. We recommended that core and unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

Concur. The Competency Assessment Form will be used to identify each core competency and each unit-specific competency. The Competency Assessment Form requires completion of the verification method (observation, demonstration, verbalization, written, test/quiz, in-service, document review, simulation or other), educational intervention, and competency code. This is specified in the policy "Evaluating Competency of Nursing Staff."

See VA Butler Healthcare OIG/CAP share point site for draft policy

Target date for completion: November 1, 2011.

Recommendation 5. We recommended that managers specify the qualifications required for individuals who perform RN competency assessment and validation.

Concur. As stated in the policy "Evaluating Competency of Nursing Staff," "Competency validation will be completed by the unit nurse manager/supervisor or designee with the appropriate knowledge, education, and experience to confirm the required skill."

See VA Butler Healthcare OIG/CAP share point site for competency checklist document.

Target date for completion: November 1, 2011.

OIG Contact and Staff Acknowledgments

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