Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04604-127

Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts

March 6, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Edith Nourse Rogers Memorial Veterans Hospital
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 December 3, 2012.

Review Results: The review covered seven activities. The facility's reported accomplishment was a pharmacy initiative to enhance medication safety and patient compliance, which also resulted in inventory reduction and cost savings.

Recommendations: We made recommendations in all seven of the following activities:

Quality Management: Ensure that the Medical Emergency Committee collects data that measures performance in responding to resuscitation events and that code reviews include screening for clinical issues prior to the codes. Include the linking of scanned documents to the correct electronic health record in the quality control policy for scanning. Include all services in the review of electronic health record quality, and analyze electronic health record quality review reports. Ensure actions taken when data analyses indicate problems or opportunities for improvement are evaluated for effectiveness in Geriatric and Extended Care Performance Improvement Council data and the Patient Flow Coordination Collaborative.

Environment of Care: Ensure that the identified cleanliness and environmental safety issues are corrected and that the Environment of Care Committee documents progress in meeting minutes. Date multi-dose medication vials when opened, and discard when expired.

Medication Management – Controlled Substances Inspections: Initiate actions to address the identified physical security deficiencies, and correct all deficiencies identified during annual surveys. Reconcile 1 day's dispensing from the pharmacy to each automated unit. Provide quarterly trend reports to the facility Director. Include the Controlled Substances Coordinator's duties in his or her position description. Appoint all controlled substances inspectors in writing, and ensure inspectors receive annual updates. Include all required elements in monthly controlled substances inspections.

Coordination of Care – Hospice and Palliative Care: Include a dedicated physician and administrative support person on the Palliative Care Consult Team. Ensure all non-hospice and palliative care staff receive end-of-life training. Attach hospice and palliative care consult responses to the consult request in the Computerized Patient Record System.

Long-Term Home Oxygen Therapy: Re-evaluate patients for home oxygen therapy annually after the first year.

Nurse Staffing: Ensure that all required staff are members of the unit-based and facility expert panels and that expert panel members receive the required training. Complete the staffing methodology process.

Construction Safety: Establish a construction safety program with a multidisciplinary committee that effectively monitors infection control, safety, and security issues during construction and renovation activities. Correct all identified infection control, safety, and security deficiencies for the Building 7 construction project.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–27 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

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. 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:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Construction 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 FY 2012 and FY 2013 through December 7, 2012, 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 Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts,* Report No. 11-02712-37, December 6, 2011).

During this review, we presented crime awareness briefings for 47 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 146 responded. We shared survey 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 Accomplishment

Pharmacy Initiative

A pharmacy program designed to enhance medication safety and compliance for patients also resulted in inventory reduction and cost savings. Pharmacists reviewed patient medication profiles and identified a significant number of patients taking multiple tablets of the same medication. The review identified patients who could be safely switched to a single dose of medication or a different, less costly but effective alternative medication. In collaboration with prescribing physicians, changes were made that had a direct impact on patient compliance and safety while concurrent inventory reductions resulted in cost savings.

The pharmacy initiative resulted in an 80 percent achievement rate in national pharmacy cost avoidance, bringing costs, including central mail out prescriptions, within 1 standard deviation of the national peer average. Locally, the initiative resulted in non-formulary drug cost reduction of 10 percent over the previous year and an overall 1 percent reduction in outpatient prescription costs.

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 complied with selected requirements within its QM program.[1]

We interviewed 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 NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
NA	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Two months of Medical Emergency Committee meeting minutes reviewed: • Data that measured the performance in responding to resuscitation events was not collected. • There was no evidence that code reviews included screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of Medical Records Review Committee meeting minutes reviewed: • Not all services were included in review of EHR quality. • EHR quality review reports were not analyzed.
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	• The quality control policy for scanning did not include the linking of scanned documents to the correct EHR.
NA	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently evaluated in Geriatric and Extended Care Performance Improvement Council data and the Patient Flow Coordination Collaborative.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that 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 complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the Medical Emergency Committee collects data that measures performance in responding to resuscitation events and that code reviews include screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.

2. We recommended that the quality control policy for scanning includes the linking of scanned documents to the correct EHR and that processes be strengthened to ensure that the review of EHR quality includes all services and that EHR quality review reports are analyzed.

3. We recommended that processes be strengthened to ensure that actions taken when data analyses indicate problems or opportunities for improvement are evaluated for effectiveness in Geriatric and Extended Care Performance Improvement Council data and the Patient Flow Coordination Collaborative.

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.[2]

We inspected five CLC and the chronic and acute mental health inpatient units. We also inspected the urgent care department and the primary care, women's health, physical therapy, and occupational therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	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.	
	The facility had a policy that detailed cleaning of equipment between patients.	
X	Patient care areas were clean.	• Two of the 12 units/areas inspected had offensive odors—urine odor in a communal bathroom and mold/mildew odor in a communal shower.
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• One or more of the following environmental deficiencies were found in 6 of the 12 units/areas inspected: (1) missing floor tiles, (2) damaged/worn furniture, (3) ceiling tiles with heavy dirt accumulation or damage from water leaks, (4) flooding in a communal shower, (5) wall penetrations, and (6) peeling paint.
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• In three of seven medication refrigerators, multi-dose vials were either expired or opened and undated.
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

NC	Areas Reviewed for the Women's Health Clinic	Findings
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

4. We recommended that facility managers correct the identified cleanliness and environmental safety issues and that the EOC Committee documents progress in EOC Committee minutes.

5. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened and discarded when expired.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 10 CS areas, the pharmacy, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	Annual physical security surveys for past 2 years reviewed: • Three identified deficiencies were not corrected, and work orders could not be located.
X	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	Automated dispensing machine inspection instructions reviewed: • Although instructions required reconciliation of 1 day's dispensing from the pharmacy to each automated unit, this was not done for any unit in any area.
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Summary of CS inspection findings for past 6 months and quarterly trend reports for past 4 quarters reviewed: • Quarterly trend reports were not provided to the facility Director.
X	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.	Position description/functional statement reviewed: • The CS Coordinator's position description did not include coordinator duties.
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • Five CS inspectors did not receive appointment letters from the facility Director prior to assuming their duties. • CS inspectors did not receive annual updates.

NC	Areas Reviewed (continued)	Findings
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of CS areas inspected during the past 6 months reviewed: • Inspection documentation did not record whether inspections were completed on the same day they were initiated. • Inspections were not assigned to prevent distinguishable patterns. • Validations of two CS transfers from one storage area to another area were not completed. • Physical counts of all unit and clinic areas during the 1st month of each quarter were not documented as completed. • Physical counts of 10 line items for all unit and clinic areas during the 2nd and 3rd month of each quarter were not documented as completed.
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation of pharmacy CS inspections during the past 6 months reviewed: • Pharmacy inspection documentation did not record whether inspections were completed on the same day they were initiated.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that managers initiate actions to address the identified physical security deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

7. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is reconciled and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that quarterly trend reports are provided to the facility Director.

9. We recommended that the CS Coordinator's duties be included in his or her position description.

10. We recommended that processes be strengthened to ensure that all CS inspectors are appointed in writing by the facility Director prior to assuming their duties.

11. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates.

12. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy and non-pharmacy areas with CS include all required elements and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 19 employee training records (4 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • A physician and an administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 15 non-HPC staff, there was no evidence that 7 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word “palliative” or “hospice” in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
X	Consult responses were attached to HPC consult requests.	• Twelve consult responses were not attached to the consult request in the Computerized Patient Record System.
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility’s specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients’ pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated physician and administrative support person.

14. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

15. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the Computerized Patient Record System.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 31 EHRs of patients enrolled in the home oxygen program, and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Six EHRs (19 percent) contained no documentation of a re-evaluation after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

16. We recommended that processes be strengthened to ensure that patients are re-evaluated for home oxygen therapy annually after the first year.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected long-term care unit (2B).[6]

We reviewed relevant documents and 18 training files, and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The unit-based expert panel followed the required processes.	• Unit 2B's panel did not include licensed practical nurses.
X	The facility expert panel followed the required processes and included all required members.	• The facility panel did not include evening and night supervisory staff.
X	Members of the expert panels completed the required training.	• None of the five members of unit 2B's panel had completed the required training. • None of the 13 members of the facility expert panel had completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	• Expert panels were not convened until July 3, 2012. • Leadership did not endorse the nursing hours per patient day proposals to complete the nurse staffing methodology process.
NA	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

17. We recommended that the annual staffing plan reassessment process ensures that all required staff are members of the unit-based and facility expert panels.

18. We recommended that members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

19. We recommended that the facility complete the staffing methodology process.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected a construction project in Building 7, where domiciliary and outpatient counseling services are offered. Additionally, we reviewed relevant documents and 10 training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	• The facility did not have a multidisciplinary committee actively providing oversight of infection control and safety precautions during construction and renovation activities.
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by multidisciplinary team members at the specified frequency and included all required elements.	• There was no evidence of a formal site inspection process related to infection control and safety precautions.
X	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	• There was no documentation of infection surveillance activities for the project.
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	• There was no Construction Safety Committee.

NC	Areas Reviewed (continued)	Findings
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Contractor records did not contain evidence of Occupational Safety and Health Administration Construction Safety training. • Two employee records did not contain evidence of initial VHA or Occupational Safety and Health Administration Construction Safety training. • Four employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years
X	Dust control requirements were met.	• There were no dust control measures in place. Sticky mats, construction barriers, and negative air pressure were not used. • Dust was present outside the second floor construction area and had been tracked into the elevator and out into the first floor of the building. • We observed construction workers cleaning tools in a restroom used by patients and staff.
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
X	Storage and security requirements were met.	• We observed contract workers who were not wearing VA-issued identification badges.
X	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.	

Recommendations

20. We recommended that the facility establish a construction safety program with a multidisciplinary committee that effectively monitors infection control, safety, and security issues during construction and renovation activities in accordance with VHA requirements.

21. We recommended that all identified infection control, safety, and security deficiencies for the Building 7 construction project be corrected and that compliance be monitored.

Facility Profile (Bedford/518) FY 2012[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$173
Number of: • **Unique Patients**	18,944
• **Outpatient Visits**	219,935
• **Unique Employees**[b] **(as of last pay period in FY 2012)**	960
Type and Number of Operating Beds: • **Hospital**	65
• **CLC**	304
• **Mental Health**	50
Average Daily Census: (through August 2012) • **Hospital**	56
• **CLC**	239
• **Mental Health**	42
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Lynn/North Shore/518GA Haverhill/518GB Gloucester/518GE Fitchburg/518GG
VISN	1

[a] All data is for FY 2012 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 of FY 2012.

Table 1

	Inpatient Scores		**Outpatient Scores**			
	FY 2011	**FY 2012**	**FY 2011**	**FY 2012**		
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	*	*	61.7	68.9	63.9	66.5
VISN	67.4	65.7	60.5	60.8	59.9	65.3
VHA	64.1	63.9	54.5	55.0	54.7	54.3

* A score is not reported because there were fewer than 30 cases.

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 5, 2013

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

Subject: **CAP Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA**

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

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

I concur with the findings of this review. Actions plans for all Recommendations for Improvement have been developed. As of February 4th, eight recommendations have already been corrected and are being monitored for sustainment.

Improvement Action Plans for the remaining recommendations are being fully implemented and will be 80% complete within the next 30 days. 100% Improvement Action Plan implementation will be complete by May 1, 2013.

(original signed by:)
Michael F. Mayo-Smith, MD, MPH
Network Director, New England Healthcare System

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 4, 2013

From: Acting Director, Edith Nourse Rogers Memorial Veterans Hospital (518/00)

Subject: **CAP Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA**

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

We concur with the findings of this review. Action plans for all Recommendations for Improvement have been developed. As of February 4th, eight recommendations have already been corrected and are being monitored for sustainment.

Improvement Action Plans for the remaining recommendations are being fully implemented and will be 80% complete within the next 30 days. 100% Improvement Action Plan implementation will be complete by May 1, 2013.

(original signed by:)
Christine Croteau
Acting Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the Medical Emergency Committee collects data that measures performance in responding to resuscitation events and that code reviews include screening for clinical issues prior to codes that may have contributed to the occurrence of the codes.

Concur

Target date for completion: January 28, 2013.

Facility response:

1. Nursing staff on Medical Emergency team attending codes on all shifts have been educated regarding accurate documentation of the resuscitation events on the event sheets.

2. Medical Emergency Committee agenda now includes monthly monitoring of documentation on CPR events, using event template.

3. Peer Review will be performed on all Medical Emergency Team calls that are a result of cardiopulmonary arrests to evaluate clinical issues prior to the code that may have contributed to the occurrence of the code. Reviews will be reported to the Medical Emergency Committee where it will be monitored, tracked and trended and reflected in their minutes Effective 01/28/2013. Medical Emergency Committee will report information on the reviews to the Medical Executive Board.

Recommendation 2. We recommended that the quality control policy for scanning includes the linking of scanned documents to the correct EHR and that processes be strengthened to ensure that the review of EHR quality includes all services and that EHR quality review reports are analyzed.

Concur

Target date for completion: February 28, 2013

Facility response**:** "Scanning of Documents for Medical Records" Policy will be updated to include the quality control process of linking scanned documents to the correct EHR. Processes for Quality Assurance will include all areas of service that request documents scanned by the facility's Centralized Scanning Unit, and will include reviewing of Outside Medical Records, Internal Medical Records, External Clinical Documents, and Administrative Documents.

EHR quality record reviews of a representative sample of all services will be reported to the Medical Records Review Committee by the HIM manager. Data will be analyzed through the committee.

Recommendation 3. We recommended that processes be strengthened to ensure that actions taken when data analyses indicate problems or opportunities for improvement are evaluated for effectiveness in Geriatric and Extended Care Performance Improvement Council data and the Patient Flow Coordination Collaborative.

Concur

Target date for completion: March 20, 2013

Facility response: The facility will build upon the revamped Quality Management Board (QMB), which is data driven and outcome focused. The Director has chartered a System Redesign team to strengthen key committees within the organization, with priority given to the key committees reporting to the QMB including the Medical Executive Board (MEB) and Administrative Executive Board (AEB). This work will include development of a tracking mechanism for identified problems and opportunities for improvement utilizing standardized SharePoint sites for each key committee. The Geriatric and Extended Care Performance Improvement Council and the Patient Flow Coordination Collaborative will be the first committees piloting this key approach. The appropriate tracking of problems/issues will be reported monthly to the Medical Executive Board (MEB) and quarterly to the Quality Management Board through the MEB, next scheduled report 3/20/2013.

Recommendation 4. We recommended that facility managers correct the identified cleanliness and environmental safety issues and that the EOC Committee documents progress in EOC Committee minutes.

Concur

Target date for completion: May 1, 2013

Facility response: A multidisciplinary Improvement Project team was assembled in September 2012 resulting in launching an automated work order system, which identifies needed work.

The monthly EOC rounds were expanded to bi-weekly rounds using a fresh eye approach. The bi-weekly rounds now include all clinical areas every 2 weeks while we continue deployment of the automated work order systems improvements. Issues identified and monitored during the EOC rounds are tracked through completion by the EOC Committee on a monthly basis.

Recommendation 5. We recommended that processes be strengthened to ensure that multi-dose medication vials are dated when opened and discarded when expired.

Concur

Target date for completion: December 17, 2012

Facility response: Pharmacy has strengthened the processes with the following actions:

1. Pharmacy has increased the hospital wide sweeps for expired medications and expired multi-dose vials from monthly to weekly effective 12/17/2012.

2. Nursing has established an internal process involving weekly audits of medication and treatment carts. This process will incorporate several checks for expired medications, multi-dose vials and other equipment effective 1/28/2013.

3. Nursing Administration will conduct random spot audits to ensure the process is being followed. Accountability for this process has been added to the Nurse Manager annual proficiency effective 01/28/2013.

The Clinical Services Performance Improvement Council (Clinical Services PIC) will monitor the processes and track and trend actions and improvements. The Clinical Services PIC will report this information to the Medical Executive Board (MEB).

Recommendation 6. We recommended that managers initiate actions to address the identified physical security deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: May 2013

Facility response: Work orders for all physical security deficiencies from the annual survey have been submitted and are in the process of completion. Any pending items are expected to be completed by May, 2013. Physical Security deficiencies from annual surveys are now tracked through completion as a part of Environment of Care (EOC) Committee agenda. A template has been implemented to document the deficiencies and corrective actions. The VA Police is accountable for entering and overseeing work orders. Corrective action plans with targeted dates of completion will be monitored by the EOC Committee and reported to the Administrative Executive Board (AEB) on a monthly basis.

Recommendation 7. We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is reconciled and that compliance be monitored.

Concur

Target date for completion: February 28, 2013

Facility response: To strengthen the process the Pharmacy has implemented the use of the report, Controlled Substance Coordinator Pharmacy Dispensing Check, which prints out daily. Effective 1/22/2013, the Controlled Substance Inspectors (CS Inspectors) use the report to reconcile what is dispensed to each cabinet for all units utilizing an automated dispensing machine. The CSC will report semi-annually to the Administrative Executive Board (AEB). Each CS Inspector has been trained as of 01/15/2013.

Recommendation 8. We recommended that processes be strengthened to ensure that quarterly trend reports are provided to the facility Director.

Concur

Target date for completion: February 28, 2013

Facility response: The fourth quarter Control Substance Trending Report was submitted to the Medical Center Director on 01/25/2013. The requirement for this activity was added to the Performance Plan of the CS Coordinator on 01/28/2013. Compliance with this OIG requirement will be monitored by AEB.

Recommendation 9. We recommended that the CS Coordinator's duties be included in his or her position description.

Concur

Target date for completion: January 28, 2013

Facility response: The position description of the CSC was modified to include the responsibilities specific to this requirement on 01/28/2013.

Recommendation 10. We recommended that processes be strengthened to ensure that all CS inspectors are appointed in writing by the facility Director prior to assuming their duties.

Concur

Target date for completion: January 28, 2013

Facility response: The Medical Center Director has signed appointment letters for the current CS Inspectors as of 01/28/2013. The CSC has implemented a standard process for new Inspectors.

Recommendation 11. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates.

Concur

Target date for completion: February 28, 2013

Facility response: All new and existing CS Inspectors will be trained or retrained by 02/28/21013. The annual updates will occur by February 28th each year. The CSC will strengthen the process by tracking and trending improvements for the annual updates. This will be monitored by the AEB.

Recommendation 12. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy and non-pharmacy areas with CS include all required elements and that compliance be monitored.

Concur

Target date for completion: February 28, 2013

Facility response: The CSC developed a template inspection form that includes all required elements and implemented the use of the form on 01/29/2013. The CSC will monitor compliance with completion of the forms and provide quarterly reports to the AEB.

Recommendation 13. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated physician and administrative support person.

Concur

Target date for completion: May 1, 2013

Facility response: A 0.25 administrative support person dedicated to the Palliative Care Coordination Team (PCCT) will be in place as of February 4, 2013. A 0.25 Certified Hospice and Palliative Care Nurse Practitioner will be assigned to the PCCT to perform consults beginning February 18, 2013. A physician specifically dedicated to the PCCT will be in place as of May 1, 2013.

Recommendation 14. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: February 28, 2013

Facility response: Bedford provides a host of end-of-life training. A gap was identified where attendance at training sessions was not captured in the TMS systems.

The well established training program, which was directed to clinical staff, will be strengthened to train non-HPC staff working with hospice patients. As of 1/28/2013, participation at training sessions is captured in TMS. The HPC team will monitor and track staff training and report to the Geriatrics and Extended Care Performance Improvement Council (Geri PIC).

Recommendation 15. We recommended that processes be strengthened to ensure that HPC consult responses are attached to the consult request in the Computerized Patient Record System.

Concur

Target date for completion: January 28, 2013

Facility response: Palliative Care consultations were being performed and documented in the patient record. The process has been strengthened by training that all members of the Palliative Care Coordination Team (PCCT) completed to attach HPC consult responses to the consult requests in the Computerized Patient Record System (CPRS). The PCCT team will monitor, track, and trend the consults in CPRS and report to the Geriatrics and Extended Care Performance Improvement Council (Geri PIC).

Recommendation 16. We recommended that processes be strengthened to ensure that patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: February 14, 2013

Facility response:

A home oxygen patient database has been developed for tracking of annual re-evaluation dates. The database will include the following information: last pulmonary clinic visit, next yearly appointment due, no show status, and action taken for all no shows and cancelled appointments. 100% of all initial patient information will be loaded by 2/14/2013 and will be updated at least twice a week. Compliance will be reported to the Specialty and Acute Care Performance Improvement Council (SAC PIC) on a quarterly basis.

The Pulmonary Health Technician has been assigned responsibility for the monitoring and follow up of the home oxygen patient data base and for ensuring the clerk has the Pulmonary follow-up visit/recall appointment scheduled at the end of their clinic visit. The Pulmonary Technician’s position description and performance plan was updated 01/29/2013 to include this responsibility.

Recommendation 17. We recommended that the annual staffing plan reassessment process ensures that all required staff are members of the unit-based and facility expert panels.

Concur

Target date for completion: February 1, 2013

Facility response: All expert unit panels with the appropriate mix of personnel for the annual staffing plan reassessment process have been identified. The expert unit panels now include at least 1 RN, 1 LPN and 1 Nursing Assistant on for all unit based panels. Evening and night supervisory staff members are also now included on the facility expert panel.

Recommendation 18. We recommended that members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: February 10, 2013

Facility response: Training is in process and all members of unit expert panels and facility expert panel will complete required training by February 10, 2013.

Recommendation 19. We recommended that the facility complete the staffing methodology process.

Concur

Target date for completion: April 15 for Long Term Care and Mental Health, May 30, 2013 for Alzheimer units

Facility response: Nursing will utilize the adjusted unit based expert panels that have been established and trained to complete the staffing methodology process.

The results of the appropriately developed nurse staffing methodology process will be utilized to evaluate nurse staffing and outcomes. Data analysis will be incorporated and reported to the Nurse Executive.

The Long Term Care units and Mental Health units will be reevaluated by April 15, 2013. The Alzheimer unit expert panels will be trained and the plan will be developed and deployed for those units by May 30, 2013. The facility will continue to identify dementia units to benchmark against. Until target completion is achieved, the facility will continue to evaluate emerging staff needs.

Recommendation 20. We recommended that the facility establish a construction safety program with a multidisciplinary committee that effectively monitors infection control, safety, and security issues during construction and renovation activities in accordance with VHA requirements.

Concur

Target date for completion: February 28, 2013

Facility response: The Construction Safety Program was in the process of being revamped at the time of the OIG review. The Construction Oversight Committee first met December 10, 2012 and continues to meet on a regular basis. The efforts of the multidisciplinary team include assessments for Infection Control and Safety. The committee tracks every open construction project on a grid and reviews for Infection Control and Safety. The committee reports the reviews to the Environment of Care (EOC) Committee on a monthly basis.

Recommendation 21. We recommended that all identified infection control, safety, and security deficiencies for the Building 7 construction project be corrected and that compliance be monitored.

Concur

Target date for completion: Completed December 7, 2012

Facility response: All identified infection control, safety, and security deficiencies for the Building 7 construction project were corrected the week of the OIG inspection. Contractor and contractor employees received additional training on properly securing a construction site. Additionally at the Engineering Staff Meeting (1/24/13), all Engineering employees were reminded of the requirements for doing work in the hospital environment. The Building 7 construction project was monitored by the Construction Safety Committee for sustained compliance until the project was completed on January 8, 2013 and no deficiencies were noted.

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Endnotes

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[7] References used for this topic included:

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- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.