Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01974-337

Combined Assessment Program Review of the Philadelphia VA Medical Center Philadelphia, Pennsylvania

September 27, 2013

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Philadelphia VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
IUS	immediate use sterilization
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
OR	operating room
PCCT	Palliative Care Consult Team
PSB	Professional Standards Board
QM	quality management
RME	reusable medical equipment
SICU	surgical intensive care unit
SPS	Sterile Processing Service
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 June 24, 2013.

Review Results: The review covered six activities and one follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Pressure Ulcer Prevention and Management
- Nurse Staffing

The facility's reported accomplishment was an improved orthopedic surgery joint replacement patient flow process, which allows patients to stay on the same unit for post-surgical care and rehabilitation.

Recommendations: We made recommendations in the following four activities and follow-up review area:

Quality Management: Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and report results to the Professional Standards Board. Gather data about observation bed use, and perform continued stay reviews on at least 75 percent of patients in acute beds. Ensure the Critical Care Committee reviews each cardiopulmonary resuscitation code episode.

Environment of Care: Ensure fire extinguisher signage is in place and operational. Require all designated hemodialysis employees to receive annual bloodborne pathogens training. Secure chemicals stored on the hemodialysis unit at all times. Ensure operating room employees who perform immediate use sterilization receive annual competency assessments.

Medication Management – Controlled Substances Inspections: Complete monthly inspections in the inpatient pharmacy, the outpatient pharmacy, and the community living center vault and for the emergency drug cache.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person and psychologist on the Palliative Care Consult Team. Ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Follow-Up on Environment of Care Issues: Correct the identified environmental hazards on the locked mental health unit, and ensure all environmental hazards on the locked mental health units are identified and corrected. Require all staff who work on locked

inpatient mental health units and Multidisciplinary Safety Inspection Team members to receive annual environmental hazards training.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–23, for the full text of the Directors' comments.) We consider recommendations 6 and 8 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 six activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Follow-Up on EOC Issues

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 May 20, 2013, 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 Philadelphia VA Medical Center, Philadelphia, Pennsylvania,* Report No. 10-02385-62, January 13, 2011). We made repeat recommendations in EOC.

During this review, we presented crime awareness briefings for 100 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 227 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Orthopedic Surgery Improvements

In FY 2012, 35 percent of the facility's patients met utilization management criteria for appropriate level of care. Orthopedic Service patients met criteria 9 percent of the time. The facility identified that the orthopedic patient flow process was negatively impacting timely transition of care and appropriate utilization of SICU and acute care beds. The traditional joint replacement protocol was to admit patients to the SICU post operatively, transfer them to a medical/surgical bed, and then transfer them to rehabilitation services, if needed, prior to discharge.

The facility convened an interdisciplinary team to study and revise the orthopedic patient flow process. The team recommended, and the facility approved, the creation of a dedicated orthopedic and rehabilitation unit. Patients with uncomplicated joint replacement surgery are admitted to the unit post operatively and remain there until discharged. The unit is staffed by physical therapists, social workers, case managers, and nursing staff, and care is provided to patients through a patient-centered team approach. SICU and 5 West nursing staff collaborate on the development of training and education to ensure nursing staff maintain orthopedic competencies. The improvement in the orthopedic surgical flow process has increased the availability of SICU and acute care beds in the facility. In FY 2013, these improvements led to a 7-day decrease in the length of stay for joint replacement patients and to achieving an 85 percent success rate for utilization management criteria for the appropriate level of 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 complied with selected requirements within its QM program.[1]

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 NC needed improvement. Any 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.	
	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.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Fourteen profiles reviewed: • Four FPPEs were not initiated. • None of the results of the 10 completed FPPEs were reported to the PSB.
	Local policy for the use of observation beds complied with selected requirements.	
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	• The facility did not gather observation bed use data.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Three quarters of continuing stay data reviewed: • For all quarters, less than 75 percent of acute inpatients were reviewed.
	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.	Six months of Critical Care Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode.

NC	Areas Reviewed (continued)	Findings
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
	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.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	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 FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the PSB.

2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

3. We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

4. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode.

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 selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the inpatient and outpatient hemodialysis units, the medicine and surgery units, two locked MH units, two intensive care units, two CLC units, the emergency department, two specialty clinics, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 28 employee training and competency files (10 hemodialysis, 8 OR, and 10 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any 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.	
X	Fire safety requirements were met.	• Blue lights were used to identify some fire extinguisher locations, but not all were illuminated. Other fire extinguishers were not visible from normal paths of travel and did not have signage identifying their location.
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	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.	
	Areas Reviewed for Hemodialysis	
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
X	Employees received training on bloodborne pathogens.	• There was no evidence that 9 employees received bloodborne pathogens training within the past 12-month period.
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
X	Selected EOC/infection prevention/safety requirements were met.	• Chemicals were stored in an unlocked cabinet.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
	The facility had policies/procedures/guidelines for IUS (flash) and monitored it.	
	Employees received required RME training and competency assessment.	
X	OR employees who performed IUS (flash) received training and competency assessment.	• Of the 6 OR employees on duty for more than 2 years who performed IUS, there was no evidence that two received annual competency assessments.
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that fire extinguisher signage be in place and operational in accordance with National Fire Protection Association Standards.

6. We recommended that processes be strengthened to ensure that all designated hemodialysis employees receive annual bloodborne pathogens training.

7. We recommended that chemicals stored on the hemodialysis unit be secured at all times and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that OR employees who perform IUS receive annual competency assessments.

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 conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, the CLC vault, and the emergency drug cache. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	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, 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.	
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: • One required monthly inspection was missed in the inpatient pharmacy, the outpatient pharmacy, and the CLC vault and for the emergency drug cache.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

9. We recommended that processes be strengthened to ensure that monthly inspections are completed in the inpatient pharmacy, the outpatient pharmacy, and the CLC vault and for the emergency drug cache 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 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any 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: • An administrative support person and psychologist 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.	• There was no evidence that seven non-HPC staff 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.	
	Consult responses were attached to HPC consult requests.	
	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

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

11. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 20 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers and 10 patients with community-acquired pressure ulcers), and 10 employee training records. 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

NC	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an inter-professional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	

NC	Areas Reviewed (continued)	Findings
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
NA	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

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 three inpatient units (acute medical/surgical, long-term care, and MH).[6]

We reviewed relevant documents and 25 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 5E, CLC unit 2C, and MH unit 7E for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Review Activity with Previous CAP Recommendations

Follow-Up on EOC Issues

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with identification of environmental hazards that represent a threat to suicidal patients on locked MH units and staff training on those hazards.[7]

Environmental Safety. VHA requires the reduction of environmental factors that may contribute to suicide attempts and other self-injurious behaviors on locked inpatient MH units. On one of two locked inpatient MH units, we found toilet paper holders that were not recessed in the wall and furniture that had anchor points that could be used for hanging.

Training. VHA requires that all staff that who work on locked inpatient MH units and members of the MSIT receive training on the environmental hazards that represent a threat to suicidal patients. There was no evidence that 49 of the 50 staff (98 percent) received annual training on the environmental hazards that represent a threat to suicidal patients.

Recommendations

12. We recommended that the identified environmental hazards on the locked MH unit be corrected and that processes be strengthened to ensure that all environmental hazards on the locked MH units are identified and corrected.

13. We recommended that processes be strengthened to ensure that all staff who work on locked inpatient MH units and MSIT members receive annual environmental hazards training.

Facility Profile (Philadelphia/642) FY 2013 through April 2013[a]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$437.6
Number (through May 2013) of:	
• **Unique Patients**	50,178
• **Outpatient Visits**	349,069
• **Unique Employees**[b]	1,848
Type and Number of Operating Beds:	
• **Hospital**	143
• **CLC**	240
• **MH**	40
Average Daily Census:	
• **Hospital**	105
• **CLC**	99
• **MH**	36
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Marshall Hall/642GA Willow Grove/642GC Gloucester/642GD
VISN Number	4

[a] All data is for FY 2013 through April 2013 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 and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	55.0	52.3	49.4	54.5	49.7	49.9
VISN	66.9	65.4	59.5	60.5	59.3	60.8
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	15.3	7.4	11.9	21.6	25.7	18.8
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[c] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 30, 2013

From: Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Philadelphia VA Medical Center, Philadelphia, PA**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

I have reviewed the information provided by the Philadelphia VA Medical Center and I am submitting it to your office as requested. I concur with all responses and target dates.

If you have any questions or require additional information, please contact Barbara Forsha, VISN 4 Quality Management Officer at 412-822-3290.

Michael E. Moreland, FACHE

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 30, 2013

From: Interim Director, Philadelphia VA Medical Center (642/00)

Subject: **CAP Review of the Philadelphia VA Medical Center, Philadelphia, PA**

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Susan M. Blake, RN, Director of Quality Management Service, at 215-823-6273.

for Daniel D. Hendee, FACHE

Interim Director

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 processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are reported to the PSB.

Concur

Target date for completion: December 31, 2013

Facility response: The FPPE for newly hired licensed independent practitioners (LIPs) had been identified as a high priority initiative by the Chief of Staff (COS). A newly-published MCM on the FPPE/OPPE process has been signed by the Pentad. This document describes a uniform requirement to initiate the FPPE process within 90 days of hire and complete it no later than 180 days after hire. Over the past 12 months, compliance with reporting FPPEs for newly hired LIPs to the PSB has consistently improved. FPPE/OPPE is a standing agenda item of MEC. Effective immediately the Medical Staff Office (MSO) supervisor will send a list to service chiefs on a monthly basis of all providers hired in the previous month; this process serves as a trigger to the service chief to submit FPPE/OPPE information. At the end of each quarter, the MSO supervisor will audit whether FPPE was received or not received, non-compliance will be reported to the COS for follow-up.

Recommendation 2. We recommended that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: September 30, 2013

Facility response: The use of observation beds on the inpatient units began April 18, 2013. There were a limited number of Veterans admitted under the observation status at the time of the OIG/CAP survey. Plans to increase the use of the observation status will include implementation of a process to appropriately monitor observation bed usage, analyze the data related to observation usage, and establish a quarterly report that analyzes the appropriateness of observation bed usage. Observation bed usage report will be submitted for discussion/oversight to the facility Quality Council (QC). QC oversight will be reported to the facility Executive Leadership Operation Council (ELOC).

Recommendation 3. We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: December 31, 2013

Facility response: Due to a resignation, there has been an identified shortage of Utilization Management (UM) reviewers to meet this measure. The emphasis has been on meeting the admission reviews. A candidate has been selected to fill this vacancy, but is not yet on board. An additional UM reviewer position has been approved. The position is currently posted on USA Jobs.gov. The additional manpower will facilitate meeting this measure.

Recommendation 4. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode.

Concur

Target date for completion: September 30, 2013

Facility response: A sub group of the Critical Care Committee began meeting July 2, 2013 on a monthly basis to review every code event. Each unique code is critically reviewed. Any issues identified are trended. The results of these reviews will be discussed at the Critical Care Committee bi-monthly. Discussions and follow up will be reflected in both the work group minutes and the Critical Care Committee minutes with concerns/findings being reported up through the Medical Executive Committee.

Recommendation 5. We recommended that fire extinguisher signage be in place and operational in accordance with National Fire Protection Association Standards.

Concur

Target date for completion: September 30, 2013

Facility response: The facility Life Safety Specialist, in conjunction with the contracting company, General Fire; will perform an assessment of all fire extinguishers including proper illumination in accordance with NFPA 10, Standard for Portable Fire Extinguishers, current Edition. The assessment of the fire extinguishers will ensure that in all areas where blue lights are used to identify the fire extinguisher locations, the blue lights will be illuminated. In all areas where the fire extinguishers are not visible from normal paths of travel, signage will be posted identifying their location. Compliance will be reported to the facility Environment of Care Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that all designated hemodialysis employees receive annual bloodborne pathogens training.

Concur

Target date for completion: Completed

Facility response: 100% of Hemodialysis Nursing staff is now compliant with Blood Borne pathogen training. The Nurse Manager (NM) will monitor for annual compliance and report summary findings to the Patient Care Service Operation Committee.

Recommendation 7. We recommended that chemicals stored on the hemodialysis unit be secured at all times and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: The Door to the room containing the chemicals is secured and locked at all times. Nurse Manager (NM) will audit for compliance on unit rounds and report summary findings to Patient Care Service Operation Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that OR employees who perform IUS receive annual competency assessments.

Concur

Target date for completion: Completed

Facility response: As of July 8th 2013, ONLY Registered Nurses are deemed competent to perform Immediate Use Sterilization (IUS). 100% of the OR RNs have been educated and assessed for competency on the process and procedure for IUS. Moving forward, competency will be assessed on an initial and annual basis. Updated completed competencies have been placed in the RNs' individual folders.

Recommendation 9. We recommended that processes be strengthened to ensure monthly inspections are completed in the inpatient pharmacy, the outpatient pharmacy, and the CLC vault and for the emergency drug cache and that compliance be monitored.

Concur

Target date for completion: September 1, 2013

Facility response: As per VHA Handbook 1108.2, "Inspection of Controlled Substances," monthly inspections will include inpatient pharmacy, the outpatient pharmacy, the CLC vault and the emergency drug cache. Compliance with inspections in these areas will

be monitored by the Controlled Substance Coordinator (CSC) and reported to the MEC on a quarterly basis.

Recommendation 10. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person and a psychologist.

Concur

Target date for completion: December 31, 2013

Facility response: In an effort to grow and develop the PCCT Program and meet the requirements as defined in VHA Directive 2008-066, PVAMC will have in place dedicated staff sufficient to meet Veteran needs as defined in the directive.

Recommendation 11. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: December 31, 2013

Facility response: All non-HPC clinical staff that provides care to patients at the end of their lives will be assigned the TMS training titled "*Leading the Way- VA Palliative Care."* The Director of HPC will monitor and report compliance to Quality Council annually.

Recommendation 12. We recommended that the identified environmental hazards on the locked MH unit be corrected and that processes be strengthened to ensure that all environmental hazards on the locked MH units are identified and corrected.

Concur

Target date for completion: December 31, 2013

Facility response: Many of the findings were corrected immediately upon being identified during the survey. The toilet paper dispensers, the book racks in the day rooms, and the hasp on the cabinet were all removed on the day of survey. The book racks from both day rooms were removed the same day they were cited. The hasp on the cabinet in the day room was removed the same day it was cited. New furniture for both dayrooms has been ordered, the purchase order number has been processed, and we are awaiting shipment. MHEOCC and routine EOC rounds will be continuing mechanisms to identify environmental issues and recommend corrective actions. These recommendations will be reported through the Environment of Care Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that all staff who work on locked inpatient MH units and MSIT members receive annual environmental hazards training.

Concur

Target date for completion: September 30, 2013

Facility response: All staff who works on locked inpatient MH units and MSIT members will receive initial and annual environmental hazards training. The evidence of training will include the presentation title, presentation date, name and title of the presenter, and full signatures of the attendees. Suicide Prevention Coordinator will monitor compliance with initial and annual training requirements and will report compliance to Quality Council bi-annually.

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Endnotes

[1] References used for this topic included:
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