Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01976-312

Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut

September 12, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

C&P	compensation and pension
CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Connecticut Healthcare System
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
PU	pressure ulcer
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 24, 2013.

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

- Construction Safety

The facility's reported accomplishments were the positive effect of the Systems Redesign Program for clinical and administrative operations, Compensation and Pension Program improvements, and contributions of the Center for Neuroscience and Regeneration/Neurorehabilitation Research.

Recommendations: We made recommendations in the following six activities:

Quality Management: Consistently complete actions from peer reviews and report them to the Peer Review Committee. Review each code episode, and critically analyze the data collected from resuscitation episodes. Implement a quality control policy for scanning, and consistently scan the results of non-VA purchased diagnostic tests into electronic health records.

Environment of Care: Ensure Environment of Care Committee minutes include results of environment of care rounds, identify who is responsible for correcting environmental deficiencies, and track deficiencies to closure. Require that restrooms and showers on inpatient areas are clean, that public restrooms and elevators are clean, that public restrooms are free from environmental safety hazards, and that automatic door opening switches in all public restrooms are operational.

Medication Management – Controlled Substances Inspections: Initiate actions to address the four identified deficiencies, and correct all deficiencies identified during annual physical security surveys. Provide timely quarterly trend reports to the facility Director, and include all required elements in the trending and analysis of the data. Inspect all required non-pharmacy and pharmacy areas with controlled substances monthly. Ensure inspectors validate two transfers of controlled substances from one storage area to another area. Consistently reconcile 1 day's dispensing from the pharmacy to each automated unit.

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

Pressure Ulcer Prevention and Management: Revise the facility pressure ulcer policy to address prevention for outpatients. Accurately document pressure ulcer location, stage, risk scale score, and date acquired. Perform and document daily skin inspections for patients at risk for or with pressure ulcers, and consistently revise prevention plans if patients' risk levels change. Provide and document pressure ulcer education for patients at risk for or with pressure ulcers and/or their caregivers. Ensure designated employees receive the required pressure ulcer training. Require that electrical medical equipment in pressure ulcer patient rooms receives an electrical safety inspection.

Nurse Staffing: Monitor the staffing methodology that was implemented in March 2013, and reassess the target nursing hours per patient day for the medical intensive care unit to more accurately plan for staffing and evaluate the actual staffing provided.

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 20–29, for the full text of the Directors' comments.) We consider recommendation 3 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

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, conversed with 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
- PU Prevention and Management
- 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 2011, FY 2012, and FY 2013 through June 27, 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 VA Connecticut Healthcare System, West Haven, Connecticut,* Report No. 10-03090-87, February 14, 2011).

During this review, we presented crime awareness briefings for 138 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 330 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

Systems Redesign Program

The Systems Redesign Program has made substantial clinical and administrative contributions to improvement efforts across the organization. In FYs 2012 and 2013, 476 employees were trained in Lean (quality improvement) methodologies. During FY 2012, 244 systems redesign projects were completed. For FY 2013 as of June 15, 2013, 94 systems redesign projects had been completed, 52 projects were active, and 49 projects had been proposed. The estimated savings from the improvement efforts in FY 2012 was $700,000, and the anticipated savings in FY 2013 is $500,000.

FY 2013's focus has been primary care, and 21 Patient Aligned Care Teams currently use Lean tools to improve patient flow. One team identified that patients often arrived at appointments without having laboratory tests that were ordered by their physicians. The team piloted calling patients 2 weeks in advance to remind them of their appointments and laboratory tests. As a result of the calls, the number of patients without laboratory tests at the time of their appointments dropped from 34 percent to 21 percent. In addition, patients not able to keep their original appointments rescheduled them instead of not showing, which opened appointment slots for other patients.

C&P Program

The facility's C&P Program staff supports veterans, their families, and survivors by providing timely, high quality C&P examinations.[a] The number of examination requests has continued to increase from approximately 500 per month during FY 2010 to approximately 900 per month during FY 2013. Staff in the C&P Program, Chief of Staff's Office, and Director's Office have built a strong relationship with staff at VBA's

[a] C&P examinations assess veterans' impairments resulting from service related injury or illness and are used to determine disability benefits for both medical treatment and monetary benefits.

Hartford Regional Office.[b] Leadership has improved coordination and ownership of outcomes by appointing service line C&P Chiefs across the specialty areas of medicine, mental health, audiology, dental, and optometry. As a result, the average time to complete a C&P examination has decreased from 38 days during FY 2011 to 16 days during FY 2013.

The Center for Neuroscience and Regeneration/Neurorehabilitation Research

The Center for Neuroscience and Regeneration/Neurorehabilitation Research was established to develop new and more effective treatments for repair and protection of the injured nervous system with the objective of promoting functional recovery. Specific disease targets include spinal cord injury, multiple sclerosis, and traumatic brain injury.

The center has identified a specific gene (one out of 30,000) that plays a key role in controlling pain signaling. The gene, Nav1.7, has been identified as a major contributor to neuropathic pain after nerve injury, traumatic limb amputation, and burn injury. Nav1.7 is now a major target in development efforts of new, more effective pain therapies. Blockers of Nav1.7 are under development as novel pain treatments that will be more effective with minimal potential for dependence and addiction compared with currently available treatments.

[b] VBA is responsible for administering VA programs that provide financial and other forms of assistance to veterans, their dependents, and survivors. VBA oversees the process for determining disability while VA medical centers provide clinical evaluation through C&P examinations.

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.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Six months of PRC meeting minutes reviewed: • Of the six actions expected to be completed, two were not reported to the PRC.
	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, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of CPR Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode. • There was no evidence that the data collected from resuscitation episodes were critically analyzed.
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
	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 facility did not have a quality control policy for scanning. Twelve EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Two test results were not scanned into the 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 actions from peer reviews are consistently completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode and that the data collected from resuscitation episodes are critically analyzed.

3. We recommended that the facility implement a quality control policy for scanning.

4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

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]

At the West Haven campus, we inspected the CLC; one medical/surgical, the telemetry/step-down, the behavioral health, and the medical intensive care inpatient units; SPS; the emergency department; and one primary care, the physical therapy, and the dialysis clinics. At the Newington campus, we inspected the urgent care and primary care clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training and competency files (10 hemodialysis, 10 operating room, 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect the results of EOC rounds. • There was no process to identify who was responsible for correcting environmental deficiencies and tracking them to closure.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Community showers or restrooms on three of five inpatient units inspected were not clean. • Elevators and public restrooms at both campuses were not clean. Additionally, public restrooms had environmental safety hazards such as damaged floors that were trip hazards and non-functional electronic automatic door opening switches.
	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.	

NC	Areas Reviewed for Hemodialysis	Findings
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
	Selected EOC/infection prevention/safety requirements were met.	
	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 immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
	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 processes be strengthened to ensure that EOC Committee minutes include results of EOC rounds, identify who is responsible for correcting environmental deficiencies, and track deficiencies to closure.

6. We recommended that processes be strengthened to ensure that restrooms and showers on inpatient units are clean.

7. We recommended that processes be strengthened to ensure that public restrooms and elevators are clean, that public restrooms are free from environmental safety hazards, and that automatic door opening switches in all public restrooms are operational.

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, and the emergency drug cache. 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
	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: • Four identified deficiencies had not been corrected.
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 consistently done for seven of the CS areas.
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: • None of the quarterly trend reports were provided timely to the facility Director, and trending and analysis of the data did not include all the elements required by VHA policy.
	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.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation of 10 CS areas inspected during the past 6 months reviewed: • Five areas were not consistently inspected monthly. • Two areas did not have consistent validation of two transfers of CS from one storage area to another area.

NC	Areas Reviewed (continued)	Findings
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: • Three required areas (emergency drug cache, methadone vault, and the Newington outpatient pharmacy) were not consistently inspected monthly.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

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

9. We recommended that processes be implemented to ensure that quarterly trend reports are provided timely to the facility Director and that trending and analysis of the data includes all elements required by VHA policy.

10. We recommended that processes be strengthened to ensure that all required non-pharmacy and pharmacy areas with CS are inspected monthly.

11. We recommended that processes be strengthened to ensure that inspectors validate 2 transfers of CS from 1 storage area to another area and that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled.

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 21 employee training records (6 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.	• An administrative support person and psychologist or other mental health provider 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 eight 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

12. We recommended that the PCCT includes a dedicated administrative support person and psychologist or other mental health provider.

13. 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.

PU Prevention and Management

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

We reviewed relevant documents, 24 EHRs of patients with PUs (10 patients with hospital-acquired PUs, 10 patients with community-acquired PUs, and 4 patients with PUs at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. 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	The facility had a PU prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	Facility PU prevention policy reviewed: • The policy did not address prevention for outpatient care.
	The facility had an interprofessional PU committee, and the membership included a certified wound care specialist.	
	PU 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.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 16 of the 24 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
X	Required activities were performed for patients determined to be at risk for PUs and for patients with PUs.	• Ten of the 24 EHRs did not contain consistent documentation that staff performed daily skin inspections. • In 8 of the 12 applicable EHRs, staff did not consistently revise prevention plans if the patients' risk levels changed.
	Required activities were performed for patients determined to not be at risk for PUs.	
	For patients at risk for and with PUs, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's PU was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NC	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver PU education, and education on PU prevention and development was provided to those at risk for and with PUs and/or their caregivers.	Facility PU patient and caregiver education requirements reviewed: • For 11 of the applicable patients at risk for/with a PU, EHRs did not contain evidence that education was provided.
X	The facility defined requirements for staff PU education, and acute care staff received training on how to administer the PU risk scale, conduct the complete skin assessment, and accurately document findings.	Facility PU staff education requirements reviewed: • Six employee training records did not contain all of the training requirements.
X	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in PU patient rooms.	Three PU patient rooms inspected. Fire safety: • In two rooms, electrical medical equipment did not have evidence of required safety inspections completed by the contractor.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that the facility PU policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

15. We recommended that processes be strengthened to ensure that acute care staff accurately document PU location, stage, risk scale score, and date acquired.

16. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections for patients at risk for or with PUs and consistently revise prevention plans if the patients' risk levels change.

17. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers.

18. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the PU risk scale, how to conduct a complete skin assessment, and how to accurately document findings.

19. We recommended that processes be strengthened to ensure that electrical medical equipment in PU patient rooms receives an electrical safety inspection.

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 mental health).[6]

We reviewed relevant documents and 22 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for the two units for which staffing data was available, the medical intensive care unit and CLC unit T3W, 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. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	• The facility expert panel was not convened until March 28, 2013.
NA	The unit-based expert panels followed the required processes and included all required members.	
NA	The facility expert panel followed the required processes and included all required members.	
NA	Members of the expert panels completed the required training.	
X	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	• The medical intensive care unit's average actual nursing hours per patient day were significantly below the target for weekdays and weekend days.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

20. We recommended that nursing managers monitor the staffing methodology that was implemented in March 2013.

21. We recommended that nurse managers reassess the target nursing hours per patient day for the medical intensive care unit to more accurately plan for staffing and evaluate the actual staffing provided.

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 the behavioral health inpatient unit renovation project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we conversed with key employees and managers. 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
	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.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	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.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

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

Facility Profile (West Haven/689) FY 2013 through April 2013[c]	
Type of Organization	Tertiary
Complexity Level	1a-High Complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$468.7
Number (through May 2013) of:	
• **Unique Patients**	50,285
• **Outpatient Visits**	468,938
• **Unique Employees**[d]	2,209
Type and Number of Operating Beds:	
• **Hospital**	135
• **CLC**	40
• **Mental Health**	32
Average Daily Census:	
• **Hospital**	114
• **CLC**	20
• **Mental Health**	20
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Waterbury/689GA Stamford/689GB Willimantic/689GC Winsted/689GD Danbury/689GE New London/689HC
VISN Number	1

[c] All data is for FY 2013 through April 2013 except where noted.
[d] 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	62.6	60.0	57.1	56.8	61.4	62.8
VISN	65.7	67.6	60.8	59.9	65.3	61.7
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.[e] 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.[f]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	14.3	9.1	8.4	20.5	24.7	19.8
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[e] 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.

[f] 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 27, 2013

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

Subject: **CAP Review of the VA Connecticut Healthcare System, West Haven, CT**

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

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

I have reviewed and concur with the action plans included in the VA Connecticut Healthcare System Draft CAP report response.

Sincerely,

(original signed by:)
Michael Mayo-Smith, MD, MPH
Network Director

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2013

From: Acting Director, VA Connecticut Healthcare System (689/00)

Subject: **CAP Review of the Connecticut VA Health Care System, West Haven, CT**

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

I have reviewed and concur with the action plans included in the VA Connecticut Healthcare System Draft CAP Report response.

Sincerely,

(original signed by:)
John Callahan
Acting Facility 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 actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: 8/1/2013

Facility response: VA Connecticut (VACT) immediately met with the chair of the PRC and redesigned the tracking grid to include an additional column to ensure that final completed action items were received and item was closed. The risk manager receives closure items and shares with committee during meeting and follows through with documenting in the tracking tool for closure. The tool will be reviewed by the risk manager monthly and compliance reported out to the Medical Staff Executive Committee (MSEC) with the PRC quarterly reports.

Recommendation 2. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode and that the data collected from resuscitation episodes are critically analyzed.

Concur

Target date for completion: 7/26/2013

Facility response: VACT CPR Committee has reformatted their minute's template to include additional information regarding each code episode as discussed with the committee beginning with the July meeting. Each episode was reviewed with the committee, summarized in the minutes and any trends will be identified and tracked through closure in the minutes. Data is summarized and analyzed for a quarterly report to the MSEC. Quarterly reports will include any issues identified via these committee code reviews.

Recommendation 3. We recommended that the facility implement a quality control policy for scanning.

Concur

Target date for completion: 7/24/2013

Facility response: VA Connecticut Healthcare System Policy 00-171 Scanning of Documents into the health record was in the concurrence process during inspection and

has since completed the process and has been posted to our policies website for all staff reference.

Recommendation 4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: 8/1/2013

Facility response: VACT met with key stakeholders in the purchased care department and implemented a verification process to assure all non-VA purchased diagnostic tests are consistently received and scanned into the record. Daily mail review is completed for any bill related to non-VA care and whether or not a radiology code is associated with that bill. Providing claim is one that is eligible for payment, if it is not accompanied by the radiology exam, claim will be rejected and record requested from Non-VA facility. Payment will be made when appropriate records are received and scanned into record. Purchased care supervisor maintains a tracking mechanism and will report any discrepancies quarterly to QM.

Recommendation 5. We recommended that processes be strengthened to ensure that EOC Committee minutes include results of EOC rounds, identify who is responsible for correcting environmental deficiencies, and track deficiencies to closure.

Concur

Target date for completion: 9/23/2013

Facility response: VACT met with key stakeholders including the Associate Director, the Chair of the EOC Committee, and Quality Management. The EOC rounding program was revised including requirements for participation, documentation, and follow-up of findings. The Associate Director was charged with overseeing the process and ensuring that the requirements were met. The schedule was reviewed to ensure that all areas were included on the schedule. Representatives from each subject area are required for each episode of EOC rounding to begin. Rounds are scheduled to begin in the Associate Director's office to verify that each subject area is covered. Each subject area expert then has 48 hours to complete findings and submit them to the Associate Director's Office. Each subject area expert is responsible for ensuring that open items are resolved timely and that work orders are entered for those items that are unable to be resolved on-site during rounds. Beginning with the September EOC Committee Meeting, a monthly report regarding the previous month's EOC activity will be presented as a standing agenda item for review and discussion regarding unresolved issues. Content will include the areas in which EOC rounds took place, all identified items (both open and closed), open items from previous rounds including efforts to resolve and responsible person, and attendance from each subject area on rounds. All items will be tracked until closure.

Recommendation 6. We recommended that processes be strengthened to ensure that restrooms and showers on inpatient units are clean.

Concur

Target date for completion: 8/5/2013

Facility response: VACT made immediate correction to identified areas while the OIG was onsite. Key stakeholders from Facilities Management Service (FMS) and the Environmental Management Service (EMS) have implemented a monthly schedule for deep cleaning to both the inpatient and outpatient restrooms. The Housekeeping Supervisor is tracking cleaning completion via the daily staffing report and physical follow up audit of areas said to be cleaned. Results will be reported quarterly to the EOC committee beginning with Quarter 4, FY 2013.

Recommendation 7. We recommended that processes be strengthened to ensure that public restrooms and elevators are clean, that public restrooms are free from environmental safety hazards, and that automatic door opening switches in all public restrooms are operational.

Concur

Target date for completion: 8/5/2013

Facility response: As mentioned in Recommendation 6, VACT made immediate correction to identified areas while the OIG was onsite. Key stakeholders from Facilities Management Service (FMS) and the Environmental Management Service (EMS) have implemented a monthly deep cleaning schedule to both the inpatient and outpatient restrooms. The Housekeeping Supervisor is tracking cleaning completion via the daily staffing report and weekly physical follow up audit of areas said to be cleaned. Results will be reported quarterly to the EOC committee beginning with Quarter 4, FY 2013. Effective 8/5/13, automatic door opening switches will be checked to assure they are operational with each cleaning of the restrooms, as well as restrooms will be evaluated for any environmental safety hazards. Safety Hazards will be reported immediately to a supervisor and the affected restroom will be taken out of service for corrective action. EMS staff will be educated on the process, along with a reeducation of the SOP for cleaning restrooms during morning huddle on 8/5/13. Any deficiencies will be reported immediately via the work order process and tracked to closure. Elevator cleaning has been changed from biweekly to daily by the third shift staff and will be monitored by the Housekeeping Supervisor. All areas are also included as part of inspection during biannual EOC rounds. FMS and EMS supervisors are currently exploring vendors to contract out for deep cleaning services to be performed on restrooms.

Recommendation 8. We recommended that managers initiate actions to address the four identified deficiencies and that processes be strengthened to ensure that all deficiencies identified during annual physical security surveys are corrected.

Concur

Target date for completion: 11/6/2013

Facility response: VACT immediately addressed outstanding physical inspection deficiencies with key stakeholders. Items within our immediate control include an additional camera in the research pharmacy to allow for full camera view and mandating that pharmacy staff use the proximity card readers controlling physical access to the pharmacy where they are available. Additional proximity card readers will be procured. Key access will be allowed in the event of a proximity card reader failure. The additional camera and additional card readers will be entered as an emergency procurement with estimated completion within 90 days. The deficiencies related to motion intrusion detectors will be included in an 8/21/2013 meeting with key stakeholders from Pharmacy Service and VA Police for a Pharmacy Security Enhancement Project to address these findings. This project will include other enhancements to overall security and will enter into the contracting process which will then determine the timeline.

Recommendation 9. We recommended that processes be implemented to ensure that quarterly trend reports are provided timely to the facility Director and that trending and analysis of the data includes all elements required by VHA policy.

Concur

Target date for completion: 12/31/2013

Facility response: As of April 2013, all quarterly reports have been up to date and presented to the facility Director timely. A new CSC has been appointed and deficiencies are tracked to closure and documented in the monthly reports with any trends summarized in the quarterly reports. Trending and analysis will include comments on: resolution of identified discrepancies and discrepancies trended by location, drug and number of doses and any documented complaints to the patient advocate. Problematic trends will be further commented on with an action plan if not resolved when the report is completed as well as any potential areas for improvement. All reports will now be routed monthly to QM for review.

Recommendation 10. We recommended that processes be strengthened to ensure that all required non-pharmacy and pharmacy areas with CS are inspected monthly.

Concur

Target date for completion: 10/1/2013

Facility response: As of May 2013, a full complement of CSI is in effect. Monthly assignments are monitored by the Deputy CSC and the Chief of Police. At this time all areas are 100% compliant with monthly inspections. All monthly reports will be routed to QM for review.

Recommendation 11. We recommended that processes be strengthened to ensure that inspectors validate 2 transfers of CS from 1 storage area to another area and that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled.

Concur

Target date for completion: 6/30/2013

Facility response: As of June 2013, all CS Inspectors have been reeducated on complete and appropriate documentation to ensure they are validating two CS transfers from one storage area to another area and that 1 day's dispensing from pharmacy to each automated unit is consistently reconciled. CSI reports are turned in monthly and verified by the Deputy CSC and the Chief of Police.

Recommendation 12. We recommended that the PCCT includes a dedicated administrative support person and psychologist or other mental health provider.

Concur

Target date for completion: 11/30/2013

Facility response: VACT has labor mapped a .25 FTEE administrative support person to the PCCT effective immediately. Effective 8/5/2013, approval to hire (1) FTEE Psychologist for support the PCCT initiative was granted by the Acting Director. Recruitment efforts will be initiated immediately by the Human Resources Department.

Recommendation 13. 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: 12/31/2013

Facility response: End of Life Care (Nursing) Talent Management System (TMS) course (non-Federal 11077) will be added to the TMS records for all non-HPC clinical staff to receive training on end of life care by 8/15/13 with expected completion by the end of this calendar year. Deficiency reports will be monitored quarterly by QM in conjunction with hospital education and the PCCT for noncompliance.

Recommendation 14. We recommended that the facility PU policy be revised to address prevention for outpatients and that compliance with the revised policy be monitored.

Concur

Target date for completion: 8/5/2013

Facility response: The VACT policy on pressure ulcers has been revised to include outpatients and compliance with the policy will be monitored by Primary Care running the Vesting Reminder Report and review records on 10% of patients identified on the list for compliance with the policy.

Recommendation 15. We recommended that processes be strengthened to ensure that acute care staff accurately document PU location, stage, risk scale score, and date acquired.

Concur

Target date for completion: 8/19/2013

Facility response: Key stakeholders within the pressure ulcer prevention interdisciplinary committee met to develop an action plan to ensure accurate documentation prior to OIG onsite assessment. The facility had moved to using the VA Nursing Outcomes Database (VANOD) template for documentation which addresses all required elements. It has been a phased roll out with expected completion by 8/19/2013 to all units.

Recommendation 16. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections for patients at risk for or with PUs and consistently revise prevention plans if the patients' risk levels change.

Concur

Target date for completion: 8/19/2013

Facility response: VANOD daily skin reassessment template is being implemented as defined in Recommendation 15, with 100% chart review for change in plan being completed by facility Wound Care Nurse (WCN). Immediate onsite correction will be made by WCN to address deficiencies.

Recommendation 17. We recommended that processes be strengthened to ensure that acute care staff provide and document PU education for patients at risk for and with PUs and/or their caregivers.

Concur

Target date for completion: 9/30/2013

Facility response: VACT has begun to implement I-med education as the sole source for pressure ulcer education. Documentation will then appear in the patient record automatically. This will be monitored monthly through the WCN chart audit along with Recommendation 16 and reviewed quarterly at interdisciplinary pressure ulcer committee.

Recommendation 18. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the PU risk scale, how to conduct a complete skin assessment, and how to accurately document findings.

Concur

Target date for completion: 9/30/2013

Facility response: Key stakeholders from the pressure ulcer committee, hospital education and nursing convened to develop a plan to ensure all designated employees receive appropriate training to administer the PU risk scale, how to conduct a complete skin assessment and how to accurately document their findings. The National Database of Nursing Quality Indicators (NDNQI) competency model had previously been added to the learning plans in TMS for all designated staff with a completion date of 9/30/2013 and is monitored by the delinquency reports in TMS by hospital education. The Nursing policy CP-17 has been updated to include use of the VANOD template and how to appropriately document using that template. Head Nurse Managers will provide the education to their staff and maintain sign in records that each staff member has been educated and understands the documentation expectations. The updated policy will be provided to designated staff and reviewed in its entirety to fulfill how to accurately document findings. Education on how to conduct a complete skin assessment will be added to the learning plans of designated staff in TMS and compliance tracked through delinquency reports by hospital education.

Recommendation 19. We recommended that processes be strengthened to ensure that electrical medical equipment in PU patient rooms receives an electrical safety inspection.

Concur

Target date for completion: 8/1/2013

Facility response: VACT immediately called the appropriate vendors to replace the inspection stickers that were missing and or illegible on the specified equipment. Preventative maintenance responsibilities were verified as being part of the vendor contract. VACT has asked that the vendor provide us with a listing of all the units inspection dates and next due date as well as to have the vendor use indelible ink from now on due to cleaning when documenting on the PM stickers, as well as a preemptive review of current equipment and replace the stickers. Process will be monitored by the Administrative Officer for Nursing in cooperation with the Chief of Logistics.

Recommendation 20. We recommended that nursing managers monitor the staffing methodology that was implemented in March 2013.

Concur

Target date for completion: 10/31/2013

Facility response: Nursing continues to collect the daily nursing hour's data and to analyze it monthly. Based upon this monthly analysis we have added the following data points to more accurately evaluate the staffing. Number of patients required for 1:1 coverage was added, as well as number of patients cared for in the MICU that are actually step-down or floor boarders and the number of hours of support the MICU received from SWAT team nurses. Nursing will reassess the target hours in our Staffing Methodology annual review in October 2013.

Recommendation 21. We recommended that nurse managers reassess the target nursing hours per patient day for the medical intensive care unit to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: 10/31/2013

Facility response: Nursing continues to collect the daily nursing hour's data for MICU and analyze it monthly. As mentioned in Recommendation 20, based upon this monthly analysis we have added several data points to more accurately evaluate the staffing. Number of patients required for 1:1 coverage was added, as well as number of patients cared for in the MICU that are actually step-down or floor boarders and the number of hours of support the MICU received from SWAT team nurses. Nursing will reassess the target hours in our Staffing Methodology annual review in October 2013.

OIG Contact and Staff Acknowledgments

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This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, the International Association of Healthcare Central Service Materiel Management, and the Association for Professionals in Infection Control and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- 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.