Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02641-50

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

January 27, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Coatesville VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
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 September 9, 2013.

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

- Quality Management
- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care
- Nurse Staffing

The facility's reported accomplishments were the implementation of a team-based outpatient mental health model of care and a promotional video that featured the Dementia Competencies at Home Program.

Recommendations: We made recommendations in the following three activities:

Environment of Care: Ensure that Environmental Management Service closets are secured at all times and that ceiling tiles are promptly replaced.

Construction Safety: Ensure that contractors receive Occupational Safety and Health Administration Construction Safety training prior to project initiation. Secure construction sites against unauthorized access.

Mental Health Residential Rehabilitation Treatment Program: Fix the cause of the pooling water outside the shower on unit 7A, and hang the identified handicapped bathroom door on unit 7A correctly. Ensure all domiciliary units are clean. Conduct and document monthly self-inspections on all domiciliary units, and ensure all medications in resident rooms are secured.

Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations

and provided acceptable improvement plans. (See Appendixes C and D, pages 18–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Nurse Staffing
- Construction Safety
- MH RRTP

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through September 9, 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 Coatesville VA Medical Center, Coatesville, Pennsylvania,* Report No. 10-02991-96, February 23, 2011).

During this review, we presented crime awareness briefings for 265 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 257 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

MH Patient-Centered Care Model

In May 2012, VHA selected the facility to participate as a pilot site in the development of a new team-based outpatient model of MH care, the Behavioral Health Interdisciplinary Program. The facility established six interdisciplinary teams. Each team is comprised of a psychiatrist, psychologist, registered nurse, social worker, licensed practical nurse, health technician, and administrative support person. Four teams are located at the main campus, a fifth team is located at the Spring City community based outpatient clinic, and a sixth team is located at the Springfield community based outpatient clinic. The model offers extended hours of care and telemental health care provided by a psychiatrist from a remote location.

Dementia Competencies at Home Program

In September 2012, VA released a promotional video about non-institutional long-term care initiatives that featured the facility's Dementia Competencies at Home Program. In addition, the program was selected to be featured on the video program *The American Veteran*.

The mission of the facility's Dementia Competencies At Home Program is to maintain veterans with dementia in their homes through structured outpatient care and in-home dementia care and with education and support for their caregivers. Patients are seen in the Golden Memory Clinic where memory and functional status are assessed. Primary care staff are available for consultation as needed. Caregivers' educational needs and care burden are also assessed and evaluated. Based on these assessments, facility staff schedule home visits with caregivers to provide education on fall prevention, wandering caused by dementia, and other topics identified in the assessments. The education provided through the home visits gives caregivers the tools they need to keep

their home safe. In addition, tele-video visits are regularly scheduled to keep VA staff in touch with caregivers and to assess veterans' functional status.

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. 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 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.	
	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.	
NA	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.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
	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.	

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 SPS area were met.[2]

We inspected the medical unit, the Domiciliary Care for Homeless Veterans RRTP, the female Domiciliary Care for Homeless Veterans RRTP, the Post-Traumatic Stress Disorders RRTP, the Substance Abuse RRTP, the inpatient locked MH unit, the CLC unit, the hospice unit, urgent care, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed four SPS employee training and competency files. 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 for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Two Environmental Management Service closets were unsecured in one of nine units/areas inspected. • There were missing ceiling tiles in a patient room on the CLC unit and in sterile supply and linen rooms on the hospice unit.
	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	
NA	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
NA	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	
NA	Employees received training on blood borne pathogens.	
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	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.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
NA	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

1. We recommended that processes be strengthened to ensure that Environmental Management Service closets are secured at all times.

2. We recommended that processes be strengthened to ensure that ceiling tiles are promptly replaced and that compliance be monitored.

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 the CS Coordinator 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. 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
	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.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

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 (15 HPC staff records and 10 non-HPC staff records), and we conversed with key employees. 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
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected 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.	
	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).[5]

We reviewed relevant documents and 32 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 1B, CLC unit 138B, and MH unit 58B 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.	

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.[6]

We inspected the new locked inpatient MH unit construction 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. 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 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.	
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	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.	
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Two contractor records did not contain evidence of OSHA Construction Safety training.
	Dust control requirements were met.	

NC	Areas Reviewed (continued)	Findings
	Fire and life safety requirements were met.	• There was an unsecured construction site with open trenches and equipment near the sidewalk that connects the main facility to the MH RRTP.
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

3. We recommended that processes be strengthened to ensure that contractors receive OSHA Construction Safety training prior to project initiation.

4. We recommended that processes be strengthened to ensure construction sites are secured against unauthorized access and that compliance be monitored.

MH RRTP

The purpose of this review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.[7]

We reviewed relevant documents and inspected the following units: (1) the Domiciliary Care for Homeless Veterans RRTP (7A), (2) the female Domiciliary Care for Homeless Veterans RRTP (8A), (3) the Post-Traumatic Stress Disorder RRTP (8B), and (4) the Substance Abuse RRTP (39A). Additionally, 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	The residential environment was clean and in good repair.	None of the four units were clean. • On 7A, we found dirty grates in the shower, pooling water outside the shower, and a dirty kitchen and day room. In addition, we identified one handicapped bathroom door that was not hung correctly, preventing it from closing. • On 8A, we found a dirty kitchen and day room. • On 8B, we found dirty grates in the shower and a dirty kitchen and day room. • On 39A, we found a dirty day room.
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
X	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	• We did not find documentation of monthly self-inspections for any of the four units.
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	

NC	Areas Reviewed (continued)	Findings
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	
X	Medications in resident rooms were secured.	• We found unsecured medications in resident rooms on units 7A, 8A, and 8B.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that the cause of the pooling water outside the shower on unit 7A be fixed and the identified handicapped bathroom door on unit 7A be hung correctly and that processes be strengthened to ensure that units 7A, 8A, 8B, and 39A are clean and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that monthly self-inspections are conducted on all MH RRTP units and documented and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that medications in resident rooms on units 7A, 8A, and 8B are secured and that compliance be monitored.

Facility Profile (Coatesville/542) FY 2013 through August 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$182.9
Number (through September 2013) of:	
• **Unique Patients**	18,026
• **Outpatient Visits**	189,067
• **Unique Employees**[b]	924
Type and Number of Operating Beds:	
• **Hospital**	54
• **CLC**	169
• **MH**	229
Average Daily Census:	
• **Hospital**	14
• **CLC**	130
• **MH**	126
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Springfield/542GA Spring City/542GE
VISN Number	4

[a] All data is for FY 2013 through August 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 scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012	FY 2013	FY 2012			
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	69.5	70.3	66.7	63.0
VISN	65.4	67.9	59.5	60.5	59.3	60.8
VHA	65.0	65.5	55.0	54.7	54.3	55.0

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

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 20, 2013

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

Subject: **Status Request – OIG CAP Review of the Coatesville VA Medical Center, Coatesville, PA**

To: VHA 10AR MRS OIG CAP Reviews
OIG Follow Up Staff (53B)

1. I have reviewed the responses provided by the Coatesville VA Medical Center and I am submitting it to your office as requested. I concur with all responses.

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

Gary W. Devansky

Attachment

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2013

From: Acting Director, Coatesville VA Medical Center (542/00)

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

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

I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Coatesville VA Medical Center. We concur with the findings and recommendations.

I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

(original signed by:)
Jonathan R. Eckman, P.E.
Acting Medical Center 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 Environmental Management Service closets are secured at all times.

Concur

Target date for completion: January 30, 2014

Facility response: Employees educated on the importance of securing the closets. Random assessments of locked closets weekly has been added to supervisory rounds. Environmental Management Services (EMS) to report monthly at Environment of Care Committee.

Recommendation 2. We recommended that processes be strengthened to ensure that ceiling tiles are promptly replaced and that compliance be monitored.

Concur

Target date for completion: January 30, 2014

Facility response: New process has been established for each unit to do a monthly environmental inspection (separate from Environment Of Care Rounds) for the purpose of addressing and resolving issues on a timely basis. Unit staff are responsible for entering work orders and reports are submitted to the safety office for review monthly. Safety will report status of work orders entered for tile replacement to Environment of Care Committee monthly.

Recommendation 3. We recommended that processes be strengthened to ensure that contractors receive OSHA Construction Safety training prior to project initiation.

Concur

Target date for completion: January 30, 2014

Facility response: Contractor and contractor employees will produce OSHA Construction training certificate prior to issuance of VA ID badge prior to the start of work on station. New process established to be monitored by contracting office and reported monthly at the Construction Safety Committee.

Recommendation 4. We recommended that processes be strengthened to ensure construction sites are secured against unauthorized access and that compliance be monitored.

Concur

Target date for completion: January 30, 2014

Facility response: Project Manager to visit each construction site at least daily to increase vigilance and ensure the safety of the construction site. Engineering to report to Construction Safety Committee monthly.

Recommendation 5. We recommended that the cause of the pooling water outside the shower on unit 7A be fixed and the identified handicapped bathroom door on unit 7A be hung correctly and that processes be strengthened to ensure that units 7A, 8A, 8B, and 39A are clean and that compliance be monitored.

Concur

Target date for completion: January 15, 2014

Facility response: Work order entered to evaluate and repair water pooling on 7A. (GP131231-006)

Work order entered to evaluate the function of the door. (RA-131206-031). Each of the identified units has been cleaned thoroughly and is being maintained daily with weekly inspections by supervisory staff from Environmental Manangement Services (EMS). EMS to report monthly to Environment of Care Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that monthly self-inspections are conducted on all MH RRTP units and documented and that compliance be monitored.

Concur

Target date for completion: January 30, 2014

Facility response: New process has been established for each unit to do a monthly environmental inspection (separate from Environment of Care Rounds) for the purpose of addressing and resolving issues on a timely basis. Unit staff are responsible for entering work orders and reports are submitted to the safety office for review monthly. Safety to report to Environment of Care Committee quarterly.

Recommendation 7. We recommended that processes be strengthened to ensure that medications in resident rooms on units 7A, 8A, and 8B are secured and that compliance be monitored.

Concur

Target date for completion: January 30, 2014

Facility response: Unit staff complete routine face checks on the unit and have added a locker security check to the process. If a locker is found unsecure with medications accessible, the medications are removed and are given to a staff member to secure and returned to veteran after re-educating veteran on the need of securing medications and locker/belongings. Staff to document education in the medical record. Quality Improvement Mental Health Nurse Coordinator (QI) will audit/compare the record of face/locker checks done by staff with the medical record for corresponding education documentation provided to veteran and report summary monthly to the STAR Committee (Survey Team Accreditation Readiness).

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Report Distribution

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U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Jim Gerlach, Pat Meehan, Joseph R. Pitts

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.
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