Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00078-364

Combined Assessment Program Review of the VA Boston Healthcare System Boston, Massachusetts

June 2, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Boston Healthcare System
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration

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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 March 16, 2015.

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

- Magnetic Resonance Imaging Safety
- Emergency Airway Management

The facility's reported accomplishments were the Allergy Team and the establishment of live Facebook® chat sessions.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure facility managers review privilege forms annually and document the review. Develop a plan to complete the conversion from a six-part credentialing and privileging folder to a two-part privileging folder.

Environment of Care: Repair floors, ceilings, and walls in patient care areas. Ensure all patient care areas are clean, and repair worn and damaged furniture or remove it from service. Ensure all furnishings on the acute behavioral health unit comply with the standards of the VA Mental Health Environment of Care Checklist.

Medication Management: Complete monthly medication storage area inspections. Require that all designated employees receive initial automated dispensing machine training and competency assessment. Ensure oral syringes are available for administration of liquid oral medications, and store them separately from parenteral syringes.

Coordination of Care: Consistently select the proper consult title.

Acute Ischemic Stroke Care: Revise the stroke policy to require the stroke team members to respond in person within 30 minutes of receiving a call. Complete and document National Institutes of Health stroke scales for each stroke patient, and screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Ensure employees who are involved in assessing and treating stroke patients receive the training required by the facility.

Surgical Complexity: Include 12-lead electrocardiogram competency assessment and validation in competency checklists for nurses on units A2 and 3N.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–33, for the full text of the Directors' comments.) We consider recommendations 1, 3, 6, and 16 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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 2014 and FY 2015 through February 2, 2015, 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 Boston Healthcare System, Boston, Massachusetts,* Report No. 12-02187-282, September 20, 2012).

During this review, we presented crime awareness briefings for 93 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 319 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

Allergy Team

The facility allergy team conducted a review focused on ensuring that patients who had a documented allergy to penicillin had "true" allergies. Patients may recall having some type of allergic reaction in the past and erroneously report the past reaction as a penicillin allergy. A medical history of penicillin allergy affects clinicians' drug choices for antibiotic therapy, particularly when penicillin is deemed the most appropriate choice.

Following collaboration with Surgery, Infectious Disease, Pulmonary, Pharmacy, and Systems Redesign, the allergy team performed intensive allergy evaluations on patients with a documented penicillin allergy who had surgery scheduled. A 14-month review of patients previously noted to be penicillin allergic indicated that 93 percent of them did not have a penicillin allergy. This allowed for not only appropriate antibiotic use but also reduced the use of more expensive antibiotics. National and international recognition led to the team's selection to present the topic at the 2015 American Academy of Allergy, Asthma, and Immunology's annual meeting.

Facebook® Chat

The facility established the first medical center Facebook® chat in VHA. The purpose of the chat was to disseminate information on important health care topics to as wide an audience as possible and to increase traffic to the facility's Facebook® page. The idea of a Facebook® chat as a creative way to disseminate information was presented to the flu committee as a means to debunk myths surrounding the influenza vaccine. The Facebook® chats also serve to bring more veterans and the general public to the

Facebook® page, where the facility provides additional valuable information on many topics.

The initial chat session resulted in 780 active visitors on the page the day of introduction, representing an increase of 24 percent over the previous week. The page received another 2,000 views without action, an increase of 428 percent over the previous week. The facility Facebook® chats continue to be a novel and creative use of social media to raise awareness of health care issues. Using this type of communication reaches far more people than traditional e-mails or other means. By using Facebook®, clinicians are able to reach a national audience as well as local veterans and employees. The chat information remains on the facility Facebook® page as a reference tool for those not able to join the chat. The chat session format is now a model for other VHA facilities across the country and represents an innovative way to promote VHA's mission of educating the community on important health care issues.

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 met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, one credentialing and privileging folder, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Facility managers did not review privilege forms annually. • The facility had not completed the conversion from a six-part credentialing and privileging folder to a two-part privileging folder and had no written plan to complete the process.	**1.** We recommended that facility managers review privilege forms annually and document the review. **2.** We recommended that the facility develop a plan to complete the conversion from a six-part credentialing and privileging folder to a two-part privileging folder.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met 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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

At the West Roxbury campus, we inspected one surgical unit, two medical units, the medical intensive care and surgical intensive care units, the spinal cord injury unit, the primary care clinic, and the Emergency Department. At the Brockton campus, we inspected one acute behavioral health unit, the spinal cord injury/long-term care unit, two CLCs, and the urgent care clinic. At the Jamaica Plain campus, we inspected the urgent care, primary care, and endoscopy clinics. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 39 employee training records (20 critical care and 19 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Two of three patient care areas at the Brockton campus had damaged floors, ceilings, and walls and dirty floors.	**3.** We recommended that the facility repair damaged floors, ceilings, and walls in patient care areas. **4.** We recommended that facility managers ensure all patient care areas are clean and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA policy reviewed, which requires that furniture be secured or heavy enough to prevent it from being picked up, thrown, or moved to block a door and that it be designed to prevent it from being pulled apart or splintered to be used as a weapon: • Bedside tables on the acute behavioral health unit were constructed of lightweight wood and particle board.	**5.** We recommended that facility managers ensure that all furnishings on the acute behavioral health unit comply with the standards of the VA Mental Health Environment of Care Checklist and monitor compliance.
	Areas Reviewed for Critical Care		
	Designated critical care employees received blood borne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• Both CLCs inspected had damaged floors, ceilings, and walls; dirty floors; and worn or damaged furnishings.	See recommendations 3 and 4. **6.** We recommended that the facility repair damaged or worn furnishings in patient care areas or remove them from service.
	The facility met infection prevention requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 15 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. We inspected the medical intensive care unit and one medical/surgical unit at the West Roxbury campus and one CLC and the urgent care clinic at the Brockton campus. Additionally, for these areas we reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The medical/surgical unit and the urgent care clinic had one or more missed monthly medication storage area inspections.	**7.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Five medical/surgical unit nursing employees did not have documentation of initial training and competency assessment for automated dispensing machines.	**8.** We recommended that facility managers ensure all designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.
X	The facility employed practices to prevent wrong-route drug errors.	• In all four areas, oral syringes were not available for employees to administer liquid oral medications when dose amounts differed from the unit dose packages supplied, and employees reported using parenteral syringes.	**9.** We recommended that facility managers ensure that oral syringes are available for oral liquid medication administration and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 41 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package. • Review and manage consults.		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Eleven consult requests (27 percent) did not include "inpatient" in the title.	**10.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 71 employees (30 randomly selected Level 1 ancillary staff and 41 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of MRI areas at the West Roxbury and the Jamaica Plain campuses. 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.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 39 patients who experienced stroke symptoms, and 17 employee training records (2 Emergency Department, 10 intensive care unit, and 5 surgery/rehabilitation), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, two critical care units, and four acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility's policy did not address the requirement for the stroke team to respond in person within 30 minutes of receiving a call.	**11.** We recommended that the facility revise the stroke policy to require the stroke team to respond in person within 30 minutes of receiving a call and that facility managers fully implement the revised policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 15 of the 29 applicable patients, clinicians did not document evidence of completion of stroke scales.	**12.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For 14 of the applicable 37 patients (38 percent), clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**13.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided printed stroke education to patients upon discharge.	• For 13 of the applicable 24 patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**14.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• Fourteen employees had not completed the training required by the facility.	**15**. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.
	The facility collected and reported required data related to stroke care.		
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Three of 10 unit nurses did not have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.	**16.** We recommended that facility managers ensure that A2 and 3N nurses have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. The facility reviewed and implemented recommendations made by the Veterans Integrated Service Network Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 12 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and 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.

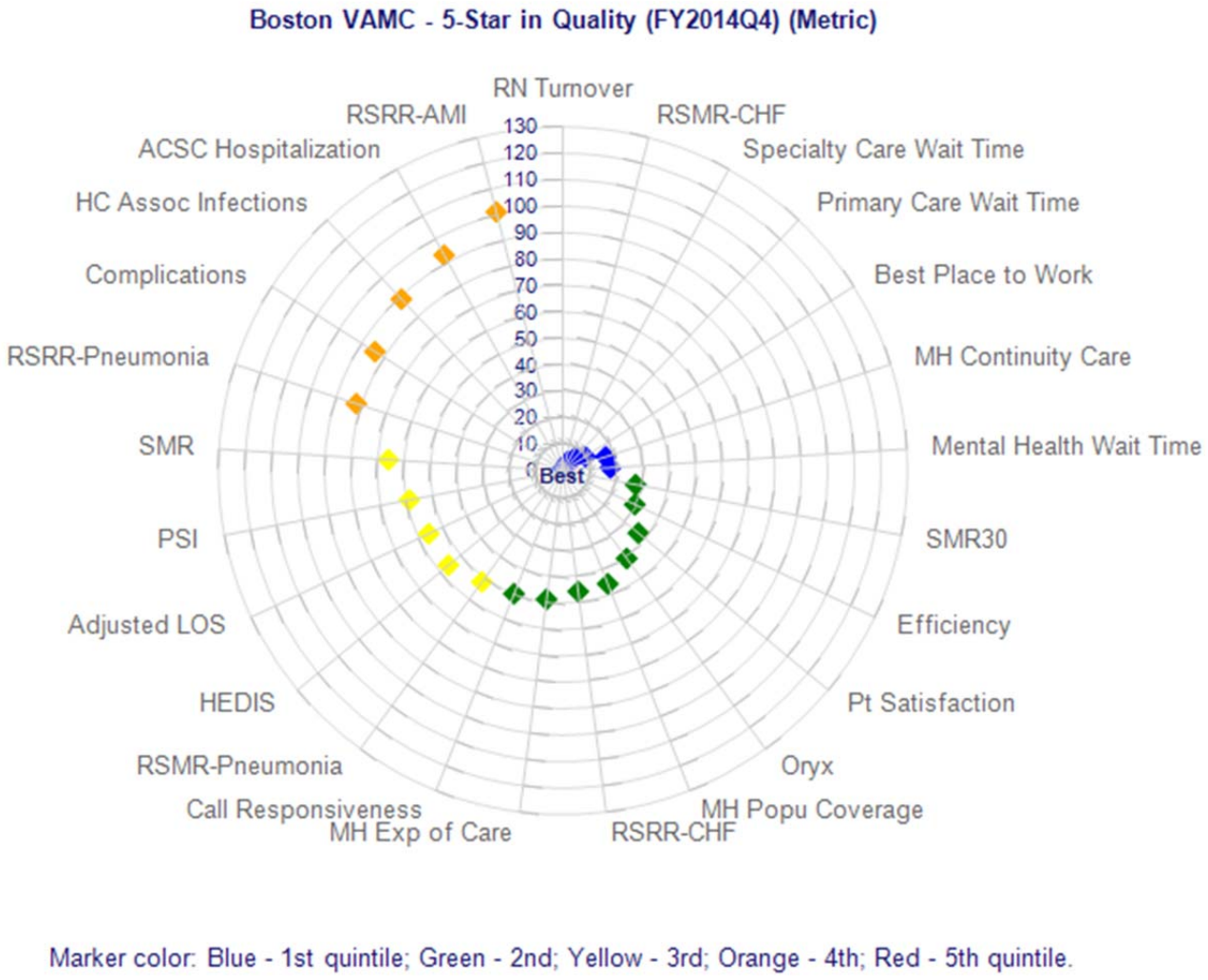
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes. • The use of equipment to confirm proper placement of breathing tubes. • A plan for managing a difficult airway.		
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test. • Successful demonstration of procedural skills on airway simulators or mannequins. • Successful demonstration of procedural skills on patients.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data. • Subject matter content elements and completion of a written test. • Successful demonstration of procedural skills on airway simulators or mannequins. • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert. • A statement related to EAM if the clinician was not a licensed independent practitioner.		
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Boston/523) FY 2015 through February 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$698.2
Number (as of March 17, 2015) of:	
• **Unique Patients**	44,044
• **Outpatient Visits**	286,836
• **Unique Employees**[2]	2,885
Type and Number of Operating Beds:	
• **Hospital**	349
• **CLC**	112
• **MH**	98
Average Daily Census:	
• **Hospital**	231
• **CLC**	88
• **MH**	64
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Boston VA-Jamaica Plain/523 Lowell/523BY Causeway/523BZ Framingham/523GA Quincy/523GC Plymouth/523GD
Veterans Integrated Service Network Number	1

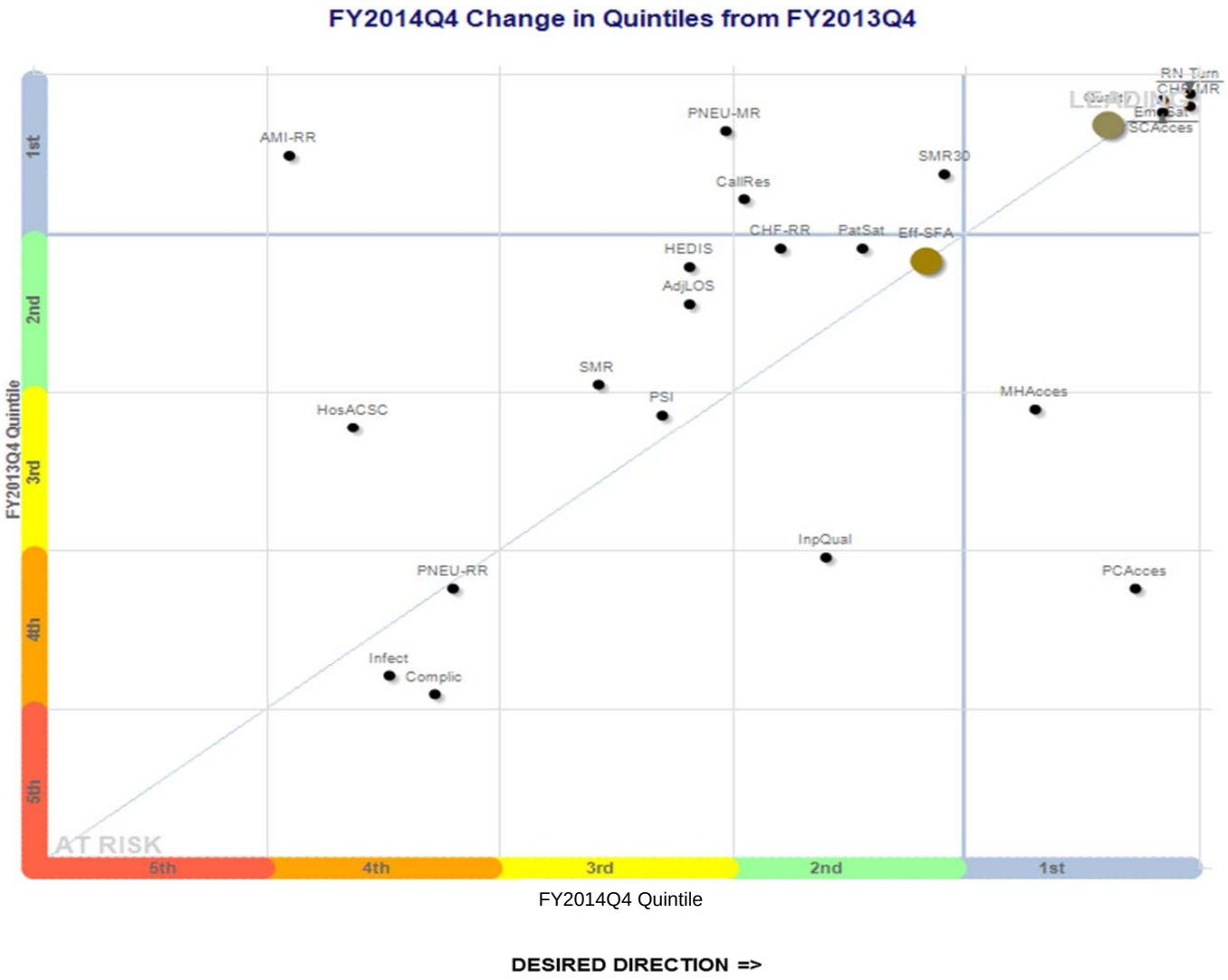
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 5, 2015

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

Subject: **CAP Review of the VA Boston Healthcare System, Boston, MA**

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 regarding the Combined Assessment Program (CAP) review conducted at the VA Boston Healthcare System.

For Michael F. Mayo-Smith, MD, MPH
Network Director
Acting chief medical officer

Facility Director Comments

Department of Veterans Affairs

Memorandum

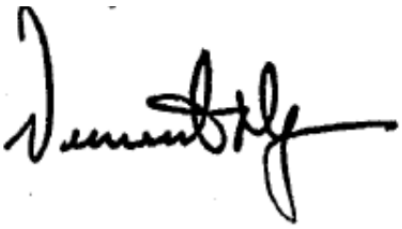
Date: May 4, 2015

From: Director, VA Boston Healthcare System (523/00)

Subject: **CAP Review of the VA Boston Healthcare System, Boston, MA**

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

I have reviewed and concur with the action plans regarding the Combined Assessment Program (CAP) review conducted at the VA Boston Healthcare System.



Vincent Ng
Director, VA Boston Healthcare System (523/00)

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 facility managers review privilege forms annually and document the review.

Concur

Target date for completion: January 15, 2015 (Completed)

Facility response: This issue was recognized in late 2014 and the privilege forms were collected and placed on SharePoint®. All current privilege forms were reviewed and documented in Medical Executive Committee minutes from January 15, 2015 and February 19, 2015. We have a process to ensure regular review going forward. The use of the PRIV*plus*® credentialing and privileging system has been expanded to allow us to run reports of providers with "high risk" privileges (including moderate sedation, out-of-operating-room airway management, procedural privileges) with greater ease than was available with the VetPro credentialing and privileging system. The PRIV*plus*® system provides the ability to generate reports for service chief verification and tracking.

Recommendation 2. We recommended that the facility develop a plan to complete the conversion from a six-part credentialing and privileging folder to a two-part privileging folder.

Concur

Target date for completion: September 30, 2015

Facility response: VA Boston Healthcare System will hire two summer staff members to complete the initial side by side comparison of VetPro files to the paper files contained in the credentialing and privileging folders. Permanent Medical Staff Office personnel will complete the second review and witnessed destruction of redundant documents. A total of 256 of the 883 provider files remain to be converted.

Recommendation 3. We recommended that the facility repair damaged floors, ceilings, and walls in patient care areas.

Concur

Target date for completion: April 20, 2015 (Completed)

Facility response: Engineering and Environmental Management Service (EMS) conducted an independent room by room inspection of walls, ceilings and floors. All deficiencies have been remedied.

Recommendation 4. We recommended that facility managers ensure all patient care areas are clean and monitor compliance.

Concur

Target date for completion: July 31, 2015

Facility response: A newly appointed Assistant Chief of EMS has been installed on the Brockton campus. He has addressed the schedule for room and floor cleaning with staff. The Assistant Chief of EMS will conduct weekly rounds.

Recommendation 5. We recommended that facility managers ensure that all furnishings on the acute behavioral health unit comply with the standards of the VA Mental Health Environment of Care Checklist and monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: A rush order for appropriate bedside tables was placed on March 24, 2015. Estimated time for delivery is June 24, 2015. Tables will be installed upon delivery.

Recommendation 6. We recommended that the facility repair damaged or worn furnishings in patient care areas or remove them from service.

Concur

Target date for completion: March 18, 2015 (Completed)

Facility response: All damaged or worn furniture was removed at the time of the site visit.

Recommendation 7. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: July 31, 2015

Facility response: All units with medication storage are to be inspected monthly by pharmacy technicians. The supervising pharmacist is responsible to sign the inspection report indicating that it has been reviewed and forward the inspection to the nurse manager of the unit. All documentation of inspections will be maintained electronically.

Compliance will be monitored until compliance is sustained at 90 percent or greater for three consecutive months.

Recommendation 8. We recommended that facility managers ensure all designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: May 31, 2015

Facility response: Nursing initial competencies have been modified to include Omnicell® automated dispensing machine training. Omnicell® competencies will be completed by those staff whose folders did not contain evidence of initial training.

Recommendation 9. We recommended that facility managers ensure that oral syringes are available for oral liquid medication administration and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: September 30, 2015

Facility response: Oral syringes have been identified by Nursing Service and the order has been placed. The purchase has to go through the contracting process. Pharmacy will supply oral syringes in the Omnicells® until the contracting process is concluded.

Recommendation 10. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2015

Facility response: Clinical Application Coordinators will update all the consult service names by May 22, 2015, in compliance with the Consult Business Rules. The Consult Committee will review monthly reports for compliance and will report rates to the Medical Executive Committee.

Recommendation 11. We recommended that the facility revise the stroke policy to require the stroke team to respond in person within 30 minutes of receiving a call and that facility managers fully implement the revised policy.

Concur

Target date for completion: July 1, 2015

Facility response: The facility policy for acute ischemic stroke will be revised to include the requirement for the stroke team to respond in person within 30 minutes of receiving a call.

Recommendation 12. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Clinicians will be educated to complete and document National Institute of Heath stroke scales for each stroke patient. Compliance will be monitored by a 100 percent chart review of all stroke patients.

Recommendation 13. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2015

Facility response: This screen is a nursing function and nurses will be educated by means of a Talent Management System curriculum that was assigned on April 13, 2015 with a deadline of May 27, 2015. The curriculum was assigned to all nursing staff working in the emergency department, intensive care units, and acute medical units. Compliance will be monitored with chart audits.

Recommendation 14. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2015

Facility response: Nursing staff have been educated to provide printed stroke education materials to all stroke patients upon discharge. Nursing staff will document in the iMed® package of the EHR that education materials were provided. Compliance will be monitored with chart audits.

Recommendation 15. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: May 27, 2015

Facility response: We have created a curriculum in the Talent Management System for Acute Ischemic Stroke education called the "Golden Hour of Acute Ischemic Stroke." The curriculum has been assigned to nursing staff in the emergency department, intensive care units, and acute medical units. This is a one-time only requirement. Continuing education will be accomplished by attendance at Basic Life Support and/or Advanced Cardiac Life Support training every other year.

Recommendation 16. We recommended that facility managers ensure that A2 and 3N nurses have 12-lead electrocardiogram competency assessment and validation included in their competency checklists.

Concur

Target date for completion: March 31, 2015 (Completed)

Facility response: It is the policy of VA Boston Healthcare System to perform only 12-lead EKGs and our nurses are assessed on their competency to perform 12-lead EKGs. Some documentation did not specify that the nurse was competent in 12-lead EKG and only referred to EKG. All competency checklists have been checked for specific reference to 12-lead EKG and those lists that lacked such language have been modified. All nurses will continue to be assessed for competency in performing 12-lead EKG.

Office of Inspector General
Contact and Staff Acknowledgments

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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, Anticoagulation Therapy Management, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, *Treatment of Acute Ischemic Stroke*, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.