
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-00598-446**

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

**July 22, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CS | controlled substances |
| EAM | emergency airway management |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Edith Nourse Rogers Memorial Veterans Hospital |
| FY | fiscal year |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| QM | quality management |
| RRTP | residential rehabilitation treatment program |
| SCI | spinal cord injury |
| 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 May 4, 2015.

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

- Coordination of Care
- Emergency Airway Management

The facility's reported accomplishments were first responder training and the hospice unit.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Review privilege forms annually, and document the review. Ensure licensed independent practitioners' folders do not contain non-allowed information. Require the Medical Emergency Committee to review each code episode and the Accident Review Board Committee to share patient handling injury data. Include required elements in the quality control policy/process for scanning.

*Environment of Care:* Clean and/or repair soiled and/or damaged wheelchairs in patient care areas, or remove them from service.

*Medication Management:* Use special medication labeling or institute unique storage practices for look-alike and sound-alike medications.

*Medication Management – Controlled Substances Inspection Program:* Provide the Facility Director with quarterly trend reports. Ensure controlled substances inspectors consistently inspect all required non-pharmacy areas with controlled substances and complete inspections on the same day initiated. Require the Controlled Substances Coordinator to sufficiently rotate inspectors in inspection assignments. Ensure the controlled substances inspection program has adequate oversight and complies with Veterans Health Administration policy.

*Mental Health Residential Rehabilitation Treatment Program:* Ensure Domiciliary Care for Homeless Veterans Program employees conduct and document monthly self-inspections.

## 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 25–30, for the full text of the Directors' comments.) We consider recommendations 3 and 5 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 seven activities:

- QM
- EOC
- Medication Management
- Medication Management – CS Inspection Program
- Coordination of Care
- EAM
- 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 2014 and FY 2015 through May 8, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we

made in our previous CAP report (*Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts,* Report No. 12-04604-127, March 6, 2013). We made a repeat recommendation in medication management – CS inspection program.

During this review, we presented crime awareness briefings for 32 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. We distributed an electronic survey to all facility employees and received 305 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

# Reported Accomplishments

## First Responder Training

Members of the Operation Enduring Freedom/Operation Iraqi Freedom and suicide prevention teams partnered with the VA Police Department at the facility to establish a training program for first responders entitled "First Responders Training, Recognizing Veterans, and Post Traumatic Stress Disorder." This training was developed in order to give first responders additional tools on how to recognize and respond to veterans they may encounter. It is based on several basic scenarios police departments often face when engaged with people in the community. VA police and a social work team facilitate the trainings, which began in September 2014. Since the implementation of the program, the team has trained 198 police officers at nine community police departments (79 who self-identified themselves as veterans). The team is negotiating to implement the training in 12 additional communities.

## Hospice Unit

The facility opened a 14-bed hospice unit on October 28, 2014, which provides a welcoming and quiet environment for veterans' end-of-life care. The unit has a full-time hospice physician; a part-time nurse practitioner; and dedicated staff consisting of nurses, social workers, and volunteers. Unlike most inpatient units with designated visiting hours, families are encouraged to visit at any time and can arrange with staff to have family meals and sleep overs. For example, a veteran's grandchildren "camped out with grandpa" overnight.

At the time of death, hospice staff drape the veteran's body with the American flag for escort from the room. Many other veterans will give the last salute as the deceased veteran passes by them. A memorial consisting of a flag in a shadowbox, a candle, and

the veteran's name is placed outside of the room in remembrance. The hospice unit collaborates with community groups, such as the Red Sox Foundation and Vettes (corvette owners) for Vets. The Red Sox Foundation once provided memorabilia for a veteran Red Sox fan that included a replica World Series ring. Vettes for Vets supplies the hospice unit with quilts for beds and other needed items. According to VHA outcome measurement data, overall family satisfaction with veterans' end-of-life care at the facility has increased from 81 percent to 90 percent since the hospice unit opened.

# 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, 10 credentialing and privileging folders, and other relevant documents. 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 |
|---|---|---|---|
| | 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.<br>• The committee routinely reviewed aggregated data.<br>• QM, patient safety, and systems redesign appeared to be integrated. | | |
| | Peer reviewed deaths met selected requirements:<br>• Peers completed reviews within specified timeframes.<br>• The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings.<br>• 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:<br>• Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.<br>• Facility managers ensured appropriate privileges for licensed independent practitioners.<br>• Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation.<br>• Facility managers properly maintained licensed independent practitioners' folders. | • Facility managers did not review privilege forms annually.<br>• All 10 licensed independent practitioners' folders reviewed contained non-allowed information. | **1.** We recommended that facility managers review privilege forms annually and document the review.<br>**2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information. |
| NA | Observation bed use met selected requirements:<br>• The facility gathered data regarding appropriateness of observation bed usage.<br>• The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more. | | |
| X | The process to review resuscitation events met selected requirements:<br>• An interdisciplinary committee reviewed episodes of care where resuscitation was attempted.<br>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.<br>• The facility collected data that measured performance in responding to events. | Ten months of Medical Emergency Committee meeting minutes reviewed:<br>• The committee did not review each episode. | **3.** We recommended that the Medical Emergency Committee review each code episode. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | The surgical review process met selected requirements:<br>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.<br>• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement.<br>• The Surgical Work Group reviewed additional data elements. | | |
| | Clinicians appropriately reported critical incidents. | | |
| X | The safe patient handling program met selected requirements:<br>• A committee provided program oversight.<br>• The committee gathered, tracked, and shared patient handling injury data. | Eight months of Accident Review Board Committee meeting minutes reviewed:<br>• The committee did not share patient handling injury data. | **4.** We recommended that the Accident Review Board Committee share patient handling injury data. |
| | The process to review the quality of entries in the EHR met selected requirements:<br>• A committee reviewed EHR quality.<br>• A committee analyzed data at least quarterly.<br>• Reviews included data from most services and program areas. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| X | The policy for scanning internal forms into EHRs included the following required items:<br>• Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate.<br>• A correction process if scanned items have errors.<br>• 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. | • The scanning policy/process did not include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability. | **5.** We recommended that the quality control policy/process for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability. |
| | 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 emergency management.[b]

We inspected six community living center units; the hospice, chronic MH, and acute MH inpatient units; and the urgent care, primary care, and dental clinics. We also performed a perimeter inspection of a community living center office renovation construction site. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. 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 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. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| | The facility met fire safety requirements. | | |
| X | The facility met environmental safety requirements. | • Eight of 12 patient care areas had soiled and/or damaged wheelchairs. | **6.** We recommended that the facility clean and/or repair soiled and/or damaged wheelchairs in patient care areas or remove them from service. |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met infection prevention requirements. | | |
| | The facility met medication safety and security requirements. | | |
| | The facility met privacy requirements. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for SCI Center** | | |
| NA | The facility completed and documented required inspection checklists of all ceiling mounted patient lifts. | | |
| NA | The facility met fire safety requirements in the SCI Center. | | |
| NA | The facility met environmental safety requirements in the SCI Center. | | |
| NA | The facility met infection prevention requirements in the SCI Center. | | |
| NA | The facility met medication safety and security requirements in the SCI Center. | | |
| NA | The facility met patient privacy requirements in the SCI Center. | | |
| NA | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Emergency Management** | | |
| | The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually. | | |
| | The facility maintained a list of resources and assets it may need during an emergency. | | |

| NM | Areas Reviewed for Emergency Management (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility had a written Emergency Operations Plan that addressed key components. | | |
| | The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time. | | |
| | Employees received training and competency assessment on use of emergency evacuation devices. | | |
| | Evacuation devices were immediately accessible and in good repair. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Construction Safety** | | |
| | The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter. | | |
| | 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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the urgent care clinic and three community living center units and for these areas 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 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 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 CS 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 |
|---|---|---|---|
| X | 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 did not use special medication labeling or institute unique storage practices for look-alike and sound-alike medications. | **7.** We recommended that the facility use special medication labeling or institute unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance. |
| | 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. | | |
| | 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 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. | | |
| | The facility employed practices to prevent wrong-route drug errors. | | |
| | Medications prepared but not immediately administered contained labels with all required elements. | | |
| | The facility removed medications awaiting destruction or stored them separately from medications available for administration. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met multi-dose insulin pen requirements. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## Medication Management – CS Inspection Program

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

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 pharmacy, and the emergency drug cache. 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 was consistent with VHA requirements. | | |
| | VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies. | | |
| | The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions. | | |
| X | The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the facility Director. | Summary of CS inspection findings for past 6 months and quarterly trend reports for past 4 quarters reviewed:<br>• The CS Coordinator did not provide quarterly trend reports to the Facility Director. This was a repeat finding from the previous CAP review. | **8.** We recommended that the Controlled Substances Coordinator provide quarterly trend reports to the Facility Director. |
| | The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | The Facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest. | | |
| X | CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements. | Documentation of 10 CS areas inspected during the past 6 months reviewed:<br>• CS inspectors did not consistently conduct monthly inspections during the past 6 months for any of the 10 areas.<br>• The CS Coordinator did not sufficiently rotate CS inspectors in inspection assignments.<br>• CS inspectors did not complete inspections on the same day initiated. | **9.** We recommended that controlled substances inspectors consistently inspect all required non-pharmacy areas with controlled substances and that the Controlled Substances Coordinator monitor compliance.<br>**10.** We recommended that facility managers ensure the Controlled Substances Coordinator sufficiently rotates controlled substances inspectors in inspection assignments and monitor compliance.<br>**11.** We recommended that controlled substances inspectors complete inspections on the same day initiated and that the Controlled Substances Coordinator monitor compliance. |
| | CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements. | | |
| X | The facility complied with any additional elements required by VHA or local policy. | VHA policy and 6 months of CS inspection documentation reviewed:<br>• The CS inspection program did not have sufficient oversight and direction to ensure compliance with VHA requirements. | **12.** We recommended that the Facility Director ensure that the controlled substances inspection program has adequate oversight and complies with Veterans Health Administration policy. |

## Coordination of Care

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

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 37 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. 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 |
|---|---|---|---|
| | A committee oversaw the facility's consult management processes. | | |
| | Major bed services had designated employees to:<br>• Provide training in the use of the computerized consult package.<br>• Review and manage consults. | | |
| | Consult requests met selected requirements:<br>• Requestors included the reason for the consult.<br>• Requestors selected the proper consult title.<br>• Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe. | | |
| | The facility met 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.[f]

We reviewed relevant documents, including the facility's exemption, 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. | | |
| NA | Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM. | | |
| NA | Facility policy addressed key VHA requirements, including:<br>• Competency assessment and reassessment processes.<br>• Use of equipment to confirm proper placement of breathing tubes.<br>• A plan for managing a difficult airway. | | |
| NA | Initial competency assessment for EAM included:<br>• Subject matter content elements and completion of a written test.<br>• Successful demonstration of procedural skills on airway simulators or mannequins.<br>• Successful demonstration of procedural skills on patients. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included:<br>• Review of clinician-specific EAM data.<br>• Subject matter content elements and completion of a written test.<br>• Successful demonstration of procedural skills on airway simulators or mannequins.<br>• 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.<br>• A statement related to EAM if the clinician was not a licensed independent practitioner. | | |
| NA | 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. | | |
| NA | Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use. | | |
| NA | The facility complied with any additional elements required by VHA or local policy. | | |

## MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans Program complied with selected EOC requirements.[g]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program, and conversed with key 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.

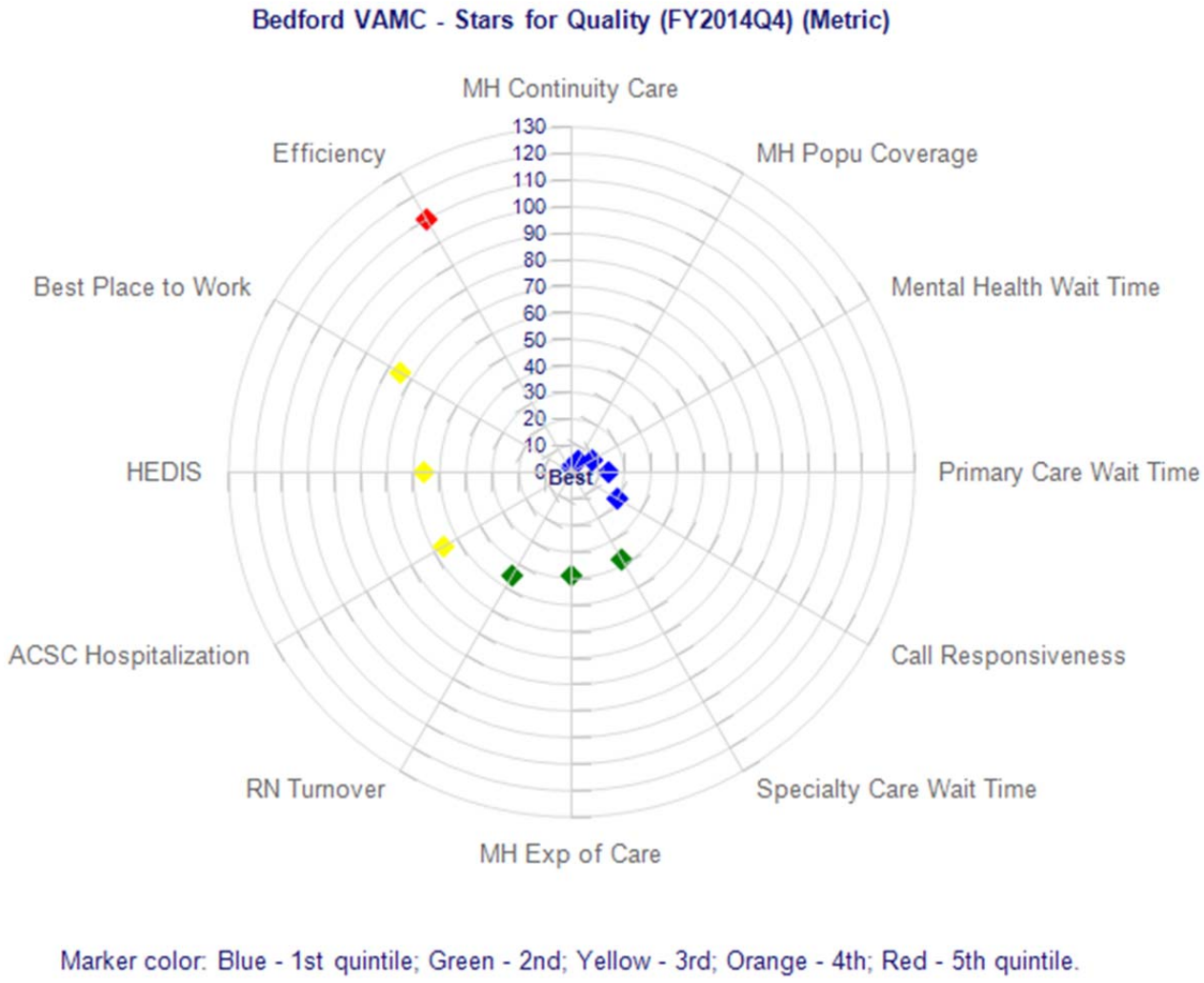
| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The residential environment was clean and in good repair. | | |
| | Appropriate fire extinguishers were available near grease producing cooking devices. | | |
| | There were policies/procedures that addressed safe medication management and contraband detection. | | |
| X | MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies. | • Domiciliary Care for Homeless Veterans Program employees did not conduct monthly self-inspections. | **13.** We recommended that Domiciliary Care for Homeless Veterans Program employees conduct and document monthly self-inspections and that program managers monitor compliance. |
| | MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications. | | |
| | The MH RRTP had written agreements in place acknowledging resident responsibility for medication security. | | |
| | MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording. | | |
| | There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process. | | |
| | In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks. | | |
| | Residents secured medications in their rooms. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

| Facility Profile (Bedford/518) FY 2015 through April 2015[1] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 3-Low complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $176 |
| **Number (as of May 6, 2015) of:** | |
| • **Unique Patients** | 15,090 |
| • **Outpatient Visits** | 162,976 |
| • **Unique Employees**[2] | 1,019 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 65 |
| • **Community Living Center** | 304 |
| • **MH** | 50 |
| **Average Daily Census:** | |
| • **Hospital** | 40 |
| • **Community Living Center** | 214 |
| • **MH** | 39 |
| **Number of Community Based Outpatient Clinics** | 4 |
| **Location(s)/Station Number(s)** | Lynn/518GA<br>Haverhill/518GB<br>Lowell/518GD<br>Gloucester/518GE |
| **Veterans Integrated Service Network Number** | 1 |

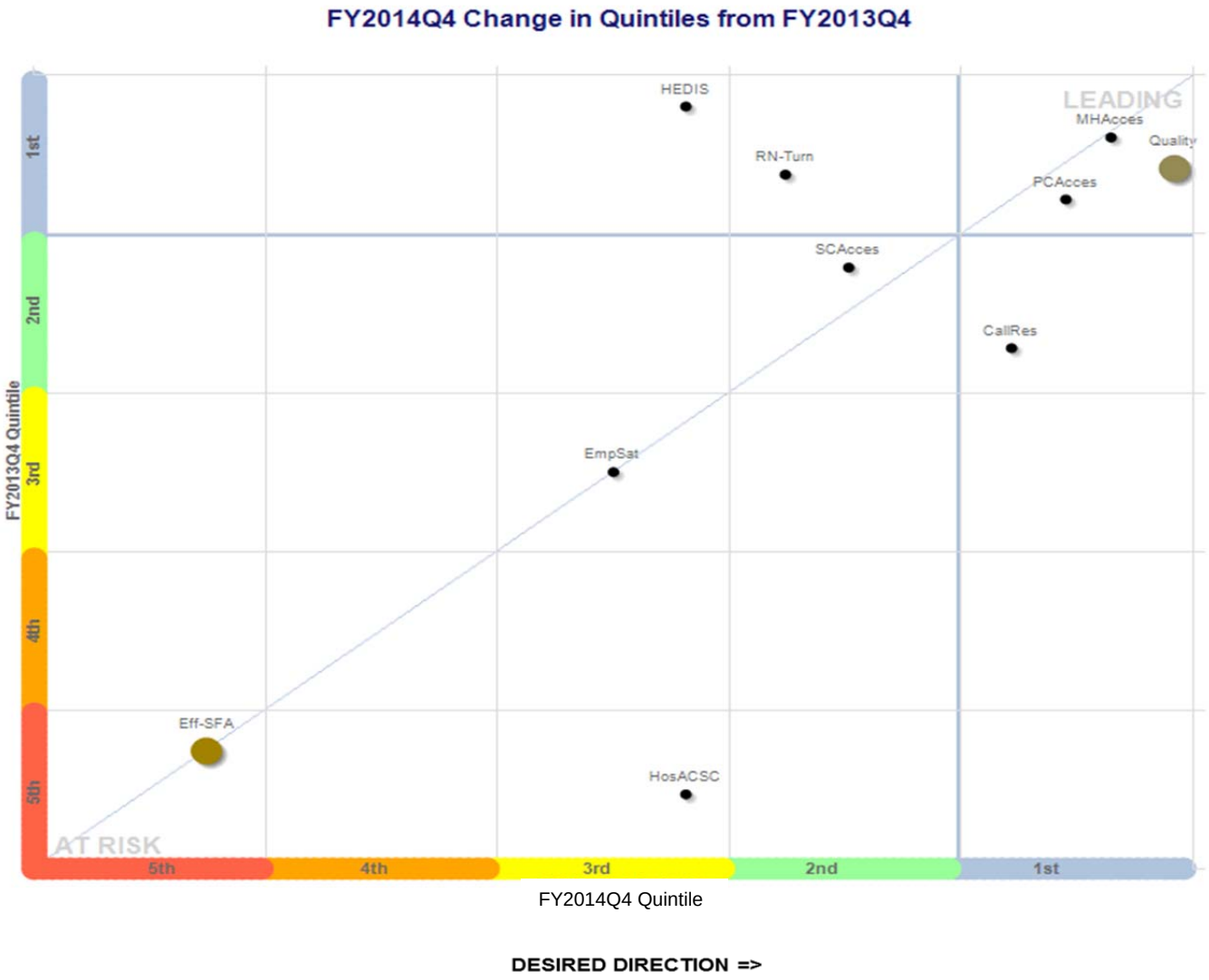
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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




[3] Metric definitions follow the graphs.

# Scatter Chart




**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 |

**Appendix C**

## Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** June 18, 2015

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

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

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

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

1. I have reviewed and concur with the action plans regarding the Combined Assessment Program (CAP) review conducted at the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA.

Sincerely,

Michael F. Mayo-Smith, MD, MPH
Network Director

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** June 15, 2015

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

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

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

1. I have reviewed and concur with the action plans regarding the Combined Assessment Program (CAP) review conducted at the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA.

Sincerely,

Christine Croteau
Facility 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 facility managers review privilege forms annually and document the review.

Concur

Target date for completion: July 30, 2015

Facility response: Standard Operating Procedure for maintenance of privilege documents will be developed and implemented. All service line managers will produce updated documents for Medical Executive Board review. The Chief of Staff office will maintain the Service Line Renewal Calendar as an ongoing agenda item.

**Recommendation 2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: August 30, 2015

Facility response: Committee Minutes will be removed from the Provider Files. This task will be incorporated into daily work assignments effective immediately.

**Recommendation 3.** We recommended that the Medical Emergency Committee review each code episode.

Concur

Target date for completion: Completed

Facility response: The Medical Emergency Committee met on June 15, 2015 and reviewed a code. The minutes document a thorough in depth analysis of the code including the report from a cardiologist. A system to ensure timely tracking and review has been implemented. As the number is so small effective immediately, each will be reported to the Medical Executive Board.

**Recommendation 4.** We recommended that the Accident Review Board Committee share patient handling injury data.

Concur

Target date for completion: August 31, 2015

Facility response: The Safety Manager will provide patient handling injury data to the Safe Patient Handling Coordinator monthly. This will be tracked and trended at the Accident Review Board.

**Recommendation 5.** We recommended that the quality control policy/process for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.

Concur

Target date for completion: Completed

Facility response: The Policy "Scanning of Documents for Computerized Medical Records", policy identifier HM136.63.AD has been updated to reflect all current requirements.

**Recommendation 6.** We recommended that the facility clean and/or repair soiled and/or damaged wheelchairs in patient care areas or remove them from service.

Concur

Target date for completion: August 31, 2015

Facility response: A sweep was conducted and all damaged wheelchairs were removed. A review has been conducted and new wheelchairs have been ordered. Wheelchairs will be part of Nursing's annual equipment needs assessment. Education of nursing staff to reinforce the need to replace damaged wheelchairs has been completed. A new wheelchair washer has been installed. A regular cleaning schedule has been established.

**Recommendation 7.** We recommended that the facility use special medication labeling or institute unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance.

Concur

Target date for completion: October 30, 2015

Facility response: The Pharmacy now utilizes "tall man lettering" in the Omnicell electronic drug file for all look-alike/sound-alike medications – completed May 2015. The Pharmacy is implementing Utilized "tall man lettering" for all 2015 look-alike/sound alike prepackaged

medications that are dispensed from the Talyst prepackage equipment – proposed completion: June 20, 2015. The Chief of Pharmacy will monitor compliance and report to the Pharmacy and Therapeutics Committee monthly starting July 1, 2015.

**Recommendation 8.** We recommended that the Controlled Substances Coordinator provide quarterly trend reports to the Facility Director.

Concur

Target date for completion: October 30, 2015

Facility response: Quarterly trend report was developed and implemented and has and will be provided to the Facility Director quarterly.

**Recommendation 9.** We recommended that controlled substances inspectors consistently inspect all required non-pharmacy areas with controlled substances and that the Controlled Substances Coordinator monitor compliance.

Concur

Target date for completion: October 30, 2015

Facility response: A schedule has been developed that includes all required non pharmacy areas with controlled substances.

**Recommendation 10.** We recommended that facility managers ensure the Controlled Substances Coordinator sufficiently rotates controlled substances inspectors in inspection assignments and monitor compliance.

Concur

Target date for completion: October 30, 2015

Facility response: We have developed a schedule to ensure Controlled Substance Inspectors rotate inspection assignments. We have increased the complement of trained inspectors. We have more than tripled the number of available inspectors. In the event an inspector is not available, a different inspector will be assigned with consideration given to past assignments.

**Recommendation 11.** We recommended that controlled substances inspectors complete inspections on the same day initiated and that the Controlled Substances Coordinator monitor compliance.

Concur

Target date for completion: October 30, 2015

Facility response: A Controlled Substance Inspection Checklist was developed and implemented. The Controlled Substance Coordinator will monitor compliance and report monthly to the Quality Management Board.

**Recommendation 12.** We recommended that the Facility Director ensure that the controlled substances inspection program has adequate oversight and complies with Veterans Health Administration policy.

Concur

Target date for completion: October 30, 2015

Facility response: The Chief of Police will provide oversight to the Controlled Substance Coordinator. The Chief of Police will ensure the Director will receive monthly reports per VHA Handbook 1108.02.

**Recommendation 13.** We recommended that Domiciliary Care for Homeless Veterans Program employees conduct and document monthly self-inspections and that program managers monitor compliance.

Concur

Target date for completion: October 15, 2015

Facility response: A new template for self-inspection has been developed and implemented. All Dorm Staff have been trained. The Nurse Manager will monitor monthly compliance. For the next three months status will be reported to the Medical Executive Board.

# Office of Inspector General
# 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: Edward J. Markey, Elizabeth Warren
U.S. House of Representatives: Seth Moulton, Niki Tsongas

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

# 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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[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] 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.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

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

[f] 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.

[g] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.