Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00616-543

Combined Assessment Program Review of the VA New Jersey Health Care System East Orange, New Jersey

September 30, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA New Jersey Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
PTSD	post-traumatic stress disorder
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the weeks of July 20 and July 27, 2015.

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

- Computed Tomography Radiation Monitoring
- Surgical Complexity

The facility's reported accomplishment was the GetWell Network.

Recommendations: We made recommendations in the following seven activities:

Quality Management: When cases receive initial Level 2 or 3 ratings, ensure the Peer Review Committee consistently invites involved providers to submit comments to and/or appear before the committee. Ensure licensed independent practitioners who perform emergency airway management are granted privileges to perform the procedure. Establish a committee to provide oversight of the safe patient handling program.

Environment of Care: Ensure Environment of Care Committee meeting minutes document discussion of environment of care rounds deficiencies and include corrective actions and tracking of actions to closure. Initiate corrective actions when sterile supply room temperature and/or humidity values are out of range. Repair or replace damaged paper towel dispensers in patient and public restrooms. Repair damaged patient equipment and furnishings, or remove them from service. Ensure designated employees receive evacuation device training.

Medication Management: Ensure crash cart logs contain the correct lock number.

Coordination of Care: Ensure requestors consistently select the proper consult title. Consistently complete inpatient consults within the specified timeframe.

Advance Directives: Follow up with inpatients who would like to discuss creating, changing, and/or revoking advance directives to ensure the discussion takes place.

Emergency Airway Management: Require that clinician reassessment for continued emergency airway management competency includes all required elements. Ensure clinicians reassessed for continued emergency airway management scope of practice have all required competency elements prior to being assigned coverage. Require that video laryngoscopes are available in all designated locations at the Lyons campus.

Mental Health Residential Rehabilitation Treatment Program: Ensure the Domiciliary Care for Homeless Veterans Program has signage alerting veterans and visitors of closed circuit television recording.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–33, for the full text of the Directors' comments.) We consider recommendation 1 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 nine activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- 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 July 23, 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 VA New Jersey Health Care System, East Orange, New Jersey,* Report No. 13-00886-210, June 13, 2013).

During this review, we presented crime awareness briefings for 271 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 448 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 Accomplishment

GetWell Network

The facility recently introduced the GetWell Network, a television-based tool, with which patients may access educational resources and communication and entertainment options. The facility is currently in the process of integrating the GetWell Network with the EHR system to measure patient outcomes for clinical interventions. Using this technology, the facility is also collecting real-time patient feedback regarding noise levels and room appearance.

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, nine 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. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
X	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.	For the 12-month period May 1, 2013, through April 30, 2014: • For several death cases that received initial Level 2 or 3 ratings, the Peer Review Committee did not invite involved providers to provide input.	**1.** We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee.

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.	• None of the nine licensed independent practitioners whose folders we reviewed had EAM privileges.	**2.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management are granted privileges to perform the procedure.
	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.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program.	**3.** We recommended that the facility establish a committee to provide oversight of the safe patient handling program.
	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 the SCI Center and emergency management.[b]

At the East Orange campus, we inspected acute psychiatry unit 12B, surgical unit 5B, medical unit 5D, SCI unit 6B, the medical and surgical intensive care unit, the Emergency Department, and the specialty Red and Blue clinics. At the Lyons campus, we inspected CLCs 1B/1C/143BW, acute psychiatry unit 143CW, and the primary care and procedure area in Building 3. Additionally, we reviewed relevant documents including documentation for 10 ceiling mounted lifts in the SCI unit and 10 nursing employee training and competency records, 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
X	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.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not include consistent discussion of EOC rounds deficiencies, corrective actions, or tracking of actions to closure.	**4.** We recommended that Environment of Care Committee meeting minutes document discussion of environment of care rounds deficiencies and include corrective actions and tracking of actions to closure.
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• In two of 11 patient care area sterile supply rooms, temperature and/or humidity values were out of acceptable range for 2 or more days during July, and there was no evidence of corrective actions. • Patient and public restrooms throughout the facility had damaged paper towel dispensers with sharp edges.	**5.** We recommended that facility managers ensure employees initiate corrective actions when sterile supply room temperature and/or humidity values are out of range and monitor compliance. **6.** We recommended that the facility repair or replace damaged paper towel dispensers in patient and public restrooms and that facility managers monitor compliance.
X	The facility met infection prevention requirements.	• Nine of 11 patient care areas had wheelchairs with tattered armrests, chairs or couches with torn surfaces, and/or furnishings with missing laminate exposing pressed wood surfaces that could not be effectively cleaned.	**7.** We recommended that the facility repair damaged patient equipment and furnishings or remove them from service and that facility managers monitor compliance.
	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		
	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
	The facility met fire safety requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
	The facility met environmental safety requirements in the SCI Center.		
	The facility met infection prevention requirements in the SCI Center.		
	The facility met medication safety and security requirements in the SCI Center.		
	The facility met patient privacy requirements in the SCI Center.		
	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.		
	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.		
X	Employees received training and competency assessment on use of emergency evacuation devices.	• None of the 10 designated nursing employees had evacuation device training in accordance with facility policy.	**8.** We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.
	Evacuation devices were immediately accessible and in good repair.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, at the East Orange campus, we inspected the Emergency Department and SCI unit 6B, and at the Lyons campus, we inspected CLCs 2B/2C 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 controlled substances partial dose wasting.		
X	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 emergency crash cart log on CLC 2C contained an incorrect lock number.	**9.** We recommended that facility managers ensure crash cart logs contain the correct lock number and monitor compliance.
	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	Recommendation
	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.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, 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.		
	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 39 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.	• Five consult requests (13 percent) did not include "inpatient" in the title. • For seven of the 35 applicable EHRs (20 percent), consultants did not change the consult request statuses within the specified timeframe.	**10.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **11.** We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 22 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 48 randomly selected patients who had a CT scan January 1–December 31, 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
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 42 randomly selected patients who had an acute care admission January 1–December 31, 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
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Three of the five applicable EHRs did not contain documentation that employees followed up with patients who indicated they wished to discuss creating, changing, and/or revoking ADs.	**12.** We recommended that employees follow up with inpatients who would like to discuss creating, changing, and/or revoking advance directives to ensure the discussion takes place and that facility managers monitor compliance.
	The facility met 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. 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
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	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 VISN 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 22 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. 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
	The facility had a local EAM policy or had a documented exemption.		
NA	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 • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	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
X	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	• None of the nine licensed independent practitioner medical officers of the day the facility designated for out of operating room airway management coverage during selected dates January–June 2014 had documentation of any of the required elements. • Eleven of 13 respiratory therapists did not have all required competency assessment elements prior to being assigned coverage January–June 2014.	**13.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance. **14.** We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have all required competency elements prior to being assigned coverage.
	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.		
X	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.	• The facility did not have video laryngoscopes available for immediate clinician use at the Lyons campus	**15.** We recommended that facility managers ensure video laryngoscopes are available in all designated locations at the Lyons campus and monitor compliance.
	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, Psychosocial RRTP, PTSD RRTP, Substance Abuse RRTP, and Women's Treatment Unit complied with selected EOC requirements.[i]

We reviewed relevant documents; inspected the Domiciliary Care for Homeless Veterans Program, Psychosocial RRTP, PTSD RRTP, Substance Abuse RRTP, and Women's Treatment Unit; 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.

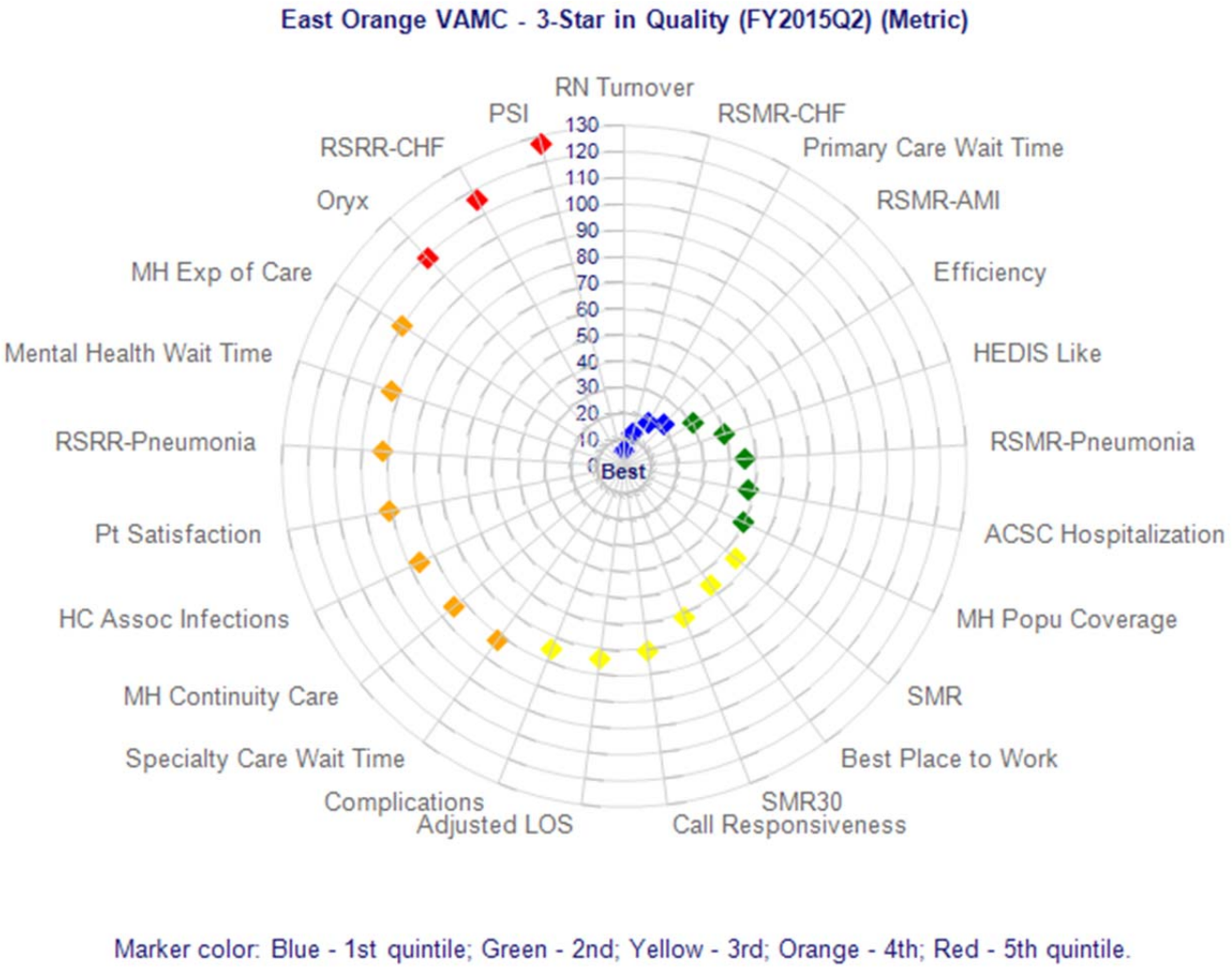
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP 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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	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.	• The Domiciliary Care for Homeless Veterans Program did not have signage alerting veterans and visitors of closed circuit television recording.	**16.** We recommended that facility managers ensure that the Domiciliary Care for Homeless Veterans Program has signage alerting veterans and visitors of closed circuit television 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 (East Orange/561) FY 2015 through June 2015[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$473.7
Number (as of July 30, 2015) of:	
• **Unique Patients**	52,794
• **Outpatient Visits**	594,594
• **Unique Employees**[2]	2,581
Type and Number of Operating Beds:	
• **Hospital**	381
• **CLC**	300
• **MH**	174
Average Daily Census:	
• **Hospital**	97
• **CLC**	203
• **MH**	135
Number of Community Based Outpatient Clinics	10
Location(s)/Station Number(s)	Newark/561BY Brick/561BZ Hamilton/561GA Elizabeth/561GB Hackensack/561GD Jersey City/561GE Piscataway/561GF Morristown/561GH Tinton Falls/561GI Paterson/561GJ
VISN Number	3

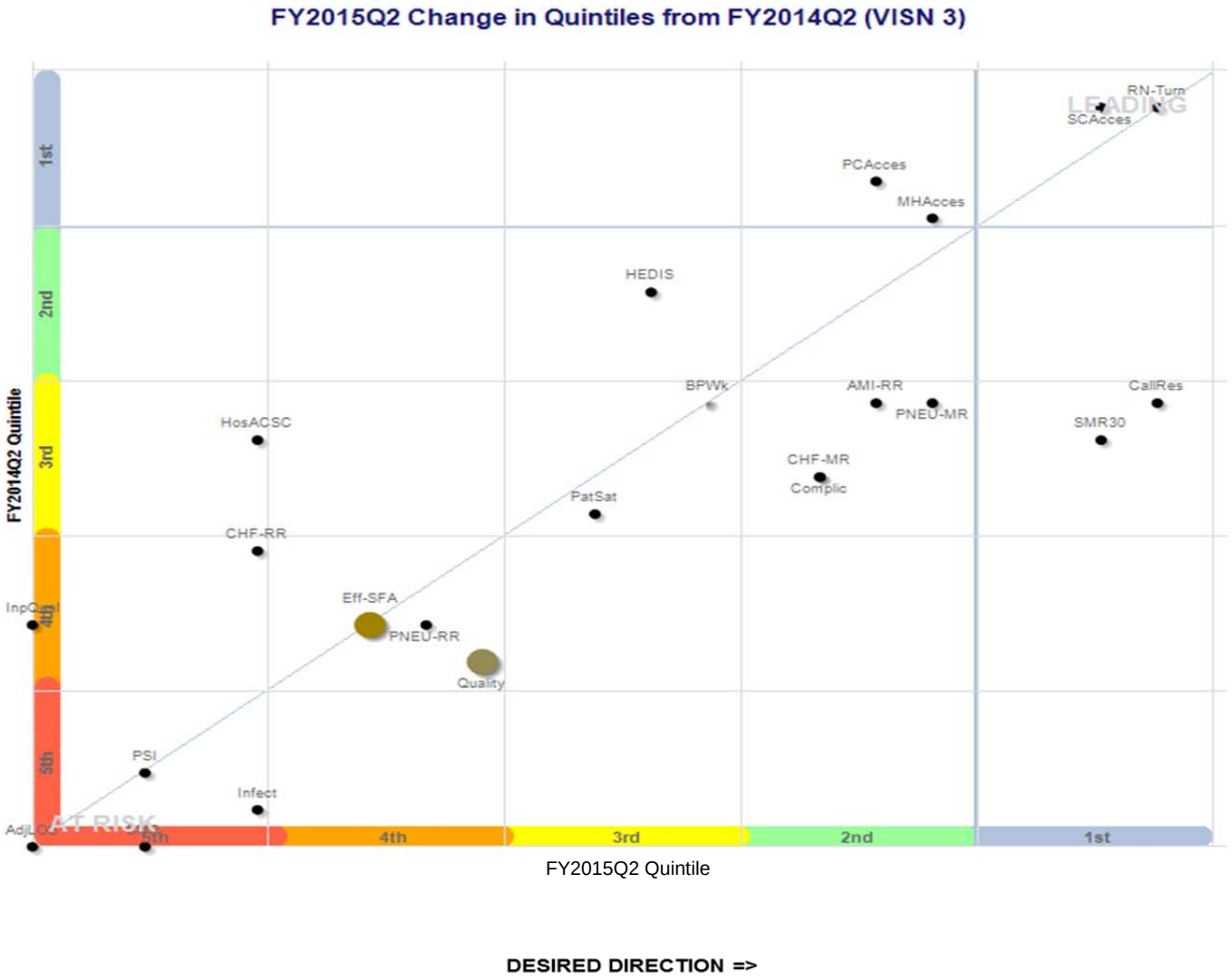
[1] All data is for FY 2015 through June 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: September 15, 2015

From: Acting Director, VA NY/NJ Veterans Healthcare Network (10N3)

Subject: **CAP Review of the VA New Jersey Health Care System, East Orange, NJ**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

Thank you for the opportunity to review the draft report of the CAP Review for VA New Jersey Health Care System. I concur with the OIG recommendations and the New Jersey HCS Director's planned corrective actions.

If additional information or assistance is needed, please contact the VISN 3 Quality Management Officer, Pam Wright, RN MSN, at 718-741-4143.

Dr. Joan McInerney, MD
Acting Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 11, 2015

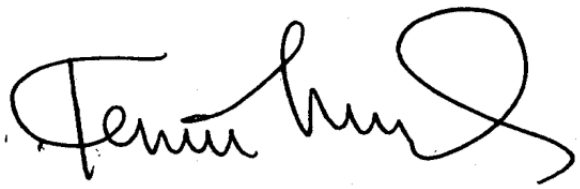
From: Director, VA New Jersey Health Care System (561/00)

Subject: **CAP Review of the VA New Jersey Health Care System, East Orange, NJ**

To: Acting Director, VA NY/NJ Veterans Healthcare Network (10N3)

Thank you for the opportunity to review the draft report of the OIG Combined Assessment Program (CAP) Review for our VA New Jersey Health Care System. I have reviewed the document and concur with the recommendations noted.

The VA New Jersey Health Care System has established corrective action plans with designated dates of completion, as detailed in the attached report. If additional information or assistance is needed, please do not hesitate to contact our Quality Coordinator, Gloria Ross, MS, PT or our Lead Accreditation Specialist, Pamela J Brooks, RN-BC, at 973 676 1000, x1215.



Kenneth H Mizrach
Director, VANJHCS

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 when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee.

Concur

Target date for completion: September 1, 2015

Facility response: VANJHCS concurs that the provider notifications were not available for the time frame under review. We corrected this deficiency as of January 1, 2015. Specifically, our current practice includes notifying providers in writing when involved in cases receiving an initial Level 2 or 3 rating. This notification includes the initial findings and the ability to provide a written or verbal statement to the Peer Review Committee. Our revised process includes saving both a hard copy of the provider notifications and electronically in the respective peer review folder. Documentation of notifications is now readily available as needed.

Recommendation 2. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management are granted privileges to perform the procedure.

Concur

Target date for completion: June 30, 2016

Facility response: VANJHCS acknowledges the importance of providing emergency airway management throughout the organization. The VANJHCS has delegated OOORAM to trained respiratory therapists deemed competent in accordance with VHA Directive 2012-032. At the Lyons Campus, the plan is to increase respiratory therapy coverage to 24/7. Currently the on call ACLS certified LIPs are responsible to respond to emergencies and codes on the night shift. Simultaneously to activating a code, Paramedics from the community are called to provide additional support and to intubate if necessary and transport the patient to the nearest community hospital. In the interim, in extraordinary circumstances that pose a threat to the well-being or safety of the patient, the clinician will exercise their judgement as to the appropriate response with the overarching goal being the care and safety of the patient. Should this occur, an RCA will be conducted as required.

Recommendation 3. We recommended that the facility establish a committee to provide oversight of the safe patient handling program.

Concur

Target date for completion: March 31, 2016

Facility response: Our VANJHCS Safe Patient Handling Program and our policy (MCM # PS-04) will be reviewed and revised to include specific oversight of this program by the Environment of Care and Patient Safety Committees.

Recommendation 4. We recommended that Environment of Care Committee meeting minutes document discussion of environment of care rounds deficiencies and include corrective actions and tracking of actions to closure.

Concur

Target date for completion: March 31, 2016

Facility response: VANJHCS acknowledges the importance of tracking to closure the discussions and corrective actions regarding EOC rounds clearly in the organization's Environment of Care Committee meeting minutes. The EOC Committee meeting minutes and agenda will be reviewed and the format revised to ensure this information is present.

Recommendation 5. We recommended that facility managers ensure employees initiate corrective actions when sterile supply room temperature and/or humidity values are out of range and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: VANJHCS acknowledges the importance of ensuring sterile supply rooms are maintained at the required temperature and humidity range; and will review and revise the organization policy MCM # EC-89 and inservice frontline staff to include criteria for when to notify Engineering and when to notify Infection Control when the ranges are out of compliance. Adherence to the revised process will be monitored to insure compliance and reported at EOC Committee.

Recommendation 6. We recommended that the facility repair or replace damaged paper towel dispensers in patient and public restrooms and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2015

Facility response: VANJHCS acknowledges the importance of environmental safety and replaced all identified damaged or cracked paper towel dispensers cited prior to the completion of the OIG CAP Survey Review. The EOC Rounds Team will be made aware of the need to pay attention to towel dispensers and other mounted equipment during rounds and our Environment Management Service (EMS) will initiate routine checking of paper towel dispensers/other dispensers in high traffic areas to ensure sustained compliance.

Recommendation 7. We recommended that the facility repair damaged patient equipment and furnishings or remove them from service and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: VANJHCS acknowledges the importance of removing damaged equipment/furnishings in order to insure safety and infection prevention. An awareness campaign will alert front line staff and supervisors as well as the EOC Team of the need to identify and remove such equipment/furniture. The Environmental Management Service (EMS) will also engage the services in an initial survey of furniture and wheelchairs to insure they are in good condition without damage or tears, and removing any in disrepair and report completion of this activity at EOC Committee.

Recommendation 8. We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: VANJHCS Emergency Management Coordinator will ensure that designated employees receive evacuation device training and report compliance to the EOC Committee.

Recommendation 9. We recommended that facility managers ensure crash cart logs contain the correct lock number and monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: VANJHCS Patient Care Services will ensure all nursing are re-trained on the importance of compliance with the organization policy (MCM # TX-59) and proper documentation on crash cart logs. The CPR Committee will monitor monthly and report findings quarterly at the CPR committee meeting.

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

Concur

Target date for completion: June 30, 2016

Facility response: The Consult Management Committee will review consult note titles and revise as necessary to ensure they have the appropriate designation. In addition, the consult policy will be reviewed (MCM # CC-09) to clarify when inpatient vs outpatient titles should be requested and staff will be educated on appropriate use of the inpatient vs outpatient consult request titles. We will conduct monitoring to ensure compliance with proper consult selection. Results will be reported to the Consult Management Committee on a monthly basis and tracked in the minutes.

Recommendation 11. We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: VANJHCS acknowledges the importance of the completion of inpatient clinical consults within the specified timeframe. Inpatient consults will be monitored monthly for timeliness of completion. Results will be reported to the Consult Management Committee on a monthly basis.

Recommendation 12. We recommended that employees follow up with inpatients who would like to discuss creating, changing, and/or revoking advance directives to ensure the discussion takes place and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: VANJHCS Patient Care Services (PCS) will ensure all nursing and social work staff are re-educated on the importance of ensuring proper discussion and documentation of our inpatients wishes concerning their Advance Directives, and that these discussions are updated as the Veteran's wishes change. PCS will also monitor compliance via electronic record review.

Recommendation 13. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: The Out of OR Airway Management policy will be reviewed to insure that competencies are appropriate and include all required elements. All staff who manages airways will be re-assessed utilizing the revised competency list. The CPR Committee will be charged with oversight to insure compliance.

Recommendation 14. We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have all required competency elements prior to being assigned coverage.

Concur

Target date for completion: December 31, 2015

Facility response: VANJHCS acknowledges that the respiratory therapists assigned during January–June 2014 did not have all the required competency assessments. All current respiratory therapists will have their EAM competency assessments reviewed annually to ensure they are in compliance with VHA Directive 2012-032.

Recommendation 15. We recommended that facility managers ensure video laryngoscopes are available in all designated locations at the Lyons campus and monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: VANJHCS acknowledges the importance of ensuring video laryngoscopy available for immediate clinician use. Currently there is one video laryngoscope available at the Lyons Campus. The Chief of Respiratory Therapy will work with the Lyons staff to determine the most appropriate location for storage so that it is readily accessible when needed (by December 31, 2015). In addition, the need for an additional video laryngoscope will be assessed and one will be purchased if it is determined that it is needed. The CPR Committee will provide oversight and track to full compliance.

Recommendation 16. We recommended that facility managers ensure that the Domiciliary Care for Homeless Veterans Program has signage alerting veterans and visitors of closed circuit television recording.

Concur

Target date for completion: December 31, 2015

Facility response: VANJHCS acknowledges the importance of alerting both veterans and visitors of the closed circuit television recording at our Domiciliary. A temporary sign was immediately posted prior to the completion of the OIG CAP Survey Review. Permanent signage has been ordered and will be installed.

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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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] 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 Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[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.

[i] 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.