Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04708-115

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

February 9, 2016

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Coatesville VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of December 7, 2015.

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

- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishment was establishing a Mobile Veterans Program to serve veterans who choose to receive care in the home and community rather than an institution.

Recommendations: We made recommendations in the following four activities:

Quality, Safety, and Value: Review Ongoing Professional Practice Evaluation data every 6 months. Implement individual improvement actions recommended by the Peer Review Committee. Require the Patient Safety Manager to enter all reported patient incidents into the WEBSPOT database and to submit an annual patient safety report to facility leaders. Revise the local protected peer review policy to be consistent with Veterans Health Administration policy.

Environment of Care: Repair damaged furniture in patient care areas, or remove it from service.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within 90 days of being hired.

Mental Health Residential Rehabilitation Treatment Program: Have a Class K fire extinguisher in the Power of Women Embracing Recovery Program kitchen. Require that Domiciliary Care for Homeless Veterans Program, Post-Traumatic Stress Disorders Residential Rehabilitation Treatment Program, and Substance Abuse Treatment Unit employees perform and document contraband inspections, daily bed checks, and resident room inspections for unsecured medications. Ensure Domiciliary Care for Homeless Veterans Program and Substance Abuse Treatment Unit residents secure medications in their rooms.

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 26–30, for the full text of the Directors' comments.) We consider recommendation 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- 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 2015 and FY 2016 through December 7, 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 Coatesville VA Medical Center, Coatesville, Pennsylvania,* Report No. 13-02641-50, January 27, 2014).

During this review, we presented crime awareness briefings for 183 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 259 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

Mobile Veterans Program

The facility established its Mobile Veterans Program in conjunction with Veteran Service Organizations in Chester, Delaware, Lancaster, and Montgomery Counties in Pennsylvania. The program brings a team of VA health care professionals to eight Veteran Service Organization locations. The team visits each site once a week. Sites are open from 9:30 a.m. to 2:30 p.m., and at some of the sites, the Veteran Service Organizations donate lunch. The team conducts a variety of educational, recreational, and social activities. Examples include therapeutic exercise, memory-focused brain exercises, and current event discussions. This novel care delivery method has allowed the facility to provide a patient-centered alternative to local veterans in anticipation of preventing the high costs associated with institutional care. The veterans benefit from structured health care in an informal environment. In addition, the program has reduced the barriers caused by distance and improved access to and compliance with care. It also provides support/respite to family caregivers.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, 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 QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Three profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.	• In three cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee.	**2.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.
	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.		
X	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.	• The Patient Safety Manager did not enter 100 patient incidents reported in FY 2015 into the WEBSPOT database. • At the completion of FY 2015, the Patient Safety Manager did not submit an annual patient safety report to facility leaders.	**3.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance. **4.** We recommended that the Patient Safety Manager submit an annual patient safety report to facility leaders at the completion of each fiscal year.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		.
	Overall, senior managers actively participated in QSV activities.		
X	The facility met any additional elements required by VHA or local policy.	Facility policy for protected peer review reviewed: • The facility's policy was not consistent with VHA requirements. For example, VHA requires that providers whose care has received an initial peer review assignment of Level 2 or 3 be invited to submit written comments to or appear before the Peer Review Committee prior to its final level determination, but facility policy states that involved providers will be invited to submit written comments or appear before the committee after review.	**5.** We recommended that the facility revise its protected peer review policy to be consistent with Veterans Health Administration policy and that facility managers monitor compliance.

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 dental clinic.[b]

We inspected the community living centers (acute, long-term care, dementia, and geropsychology units), locked acute inpatient MH unit, Substance Abuse Treatment Unit, primary care clinic, womens' health clinic, urgent care center, and dental clinic. Additionally, we reviewed relevant documents and seven employee training records, and we 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 between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Three of nine patient care areas contained damaged furniture.	**6.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service.
	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 Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (5 pharmacists and 5 technicians). Additionally, we inspected one area where sterile products are compounded. 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 policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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
NA	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
NA	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
NA	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
NA	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with 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 four CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 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 34 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. 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 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.		
	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.		
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new 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 facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Two of the five applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**7.** We recommended that the facility ensure new clinical employees complete suicide risk management training within 90 days of being hired and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	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, Substance Abuse Treatment Unit, Post-Traumatic Stress Disorders RRTP, and the Power of Women Embracing Recovery Program complied with selected EOC requirements.[h]

We reviewed relevant documents; inspected the Domiciliary Care for Homeless Veterans Program, Substance Abuse Treatment Unit, Post-Traumatic Stress Disorders RRTP, and the Power of Women Embracing Recovery Program; and conversed with key 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.

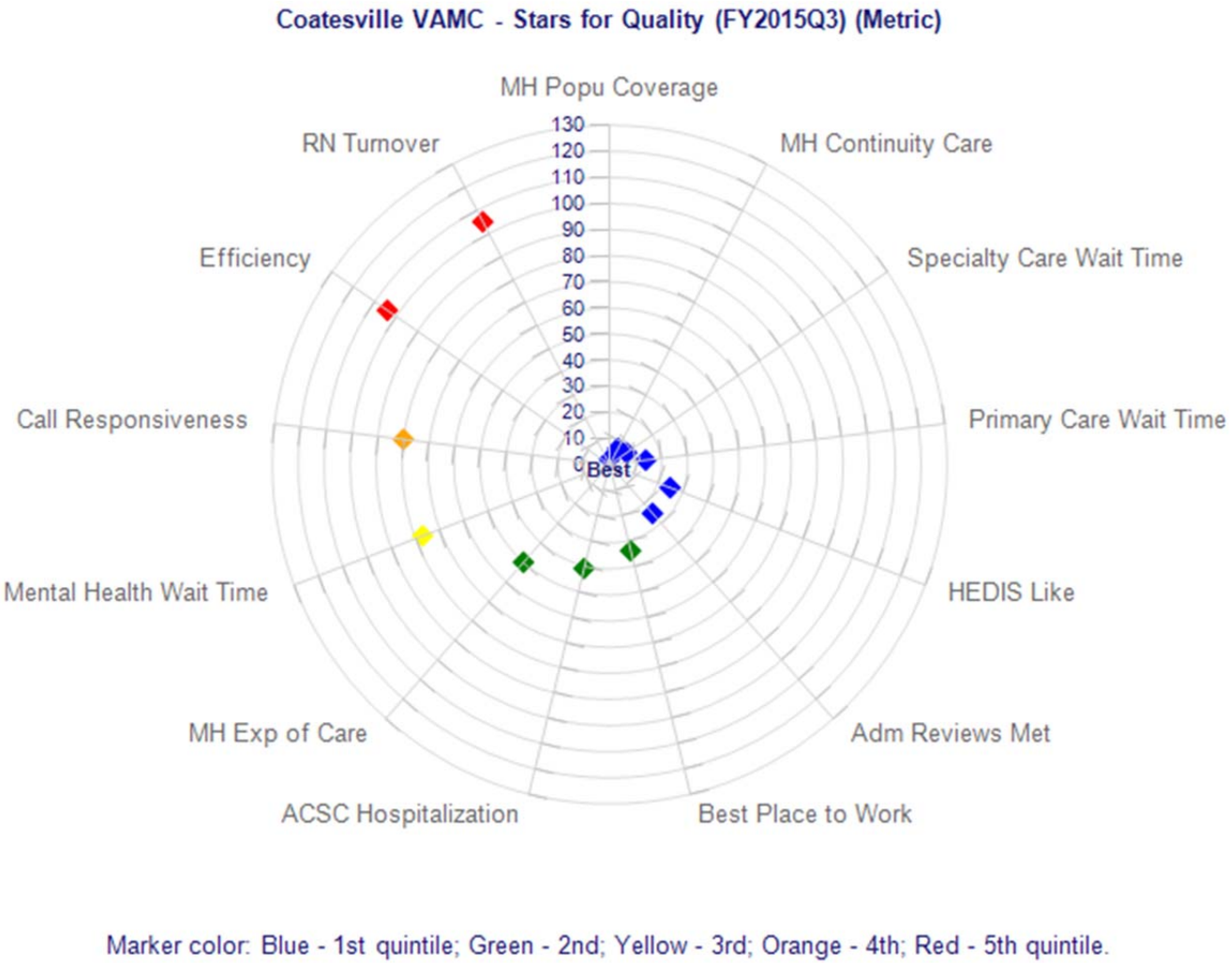
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
X	Appropriate fire extinguishers were available near grease producing cooking devices.	• The Power of Women Embracing Recovery Program kitchen did not have a Class K fire extinguisher available.	**8.** We recommended that the Power of Women Embracing Recovery Program have a Class K fire extinguisher available in the kitchen used by residents.
	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.		
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	• Domiciliary Care for Homeless Veterans Program, Post-Traumatic Stress Disorders RRTP, and Substance Abuse Treatment Unit employees did not consistently document contraband inspections, daily bed checks, and resident room inspections for unsecured medications.	**9.** We recommended that Domiciliary Care for Homeless Veterans Program, Post-Traumatic Stress Disorders Residential Rehabilitation Treatment Program, and Substance Abuse Treatment Unit employees consistently perform and document contraband inspections, daily bed checks, and resident room inspections for unsecured medications and that program/unit managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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.		
NA	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
X	Residents secured medications in their rooms.	• One resident room in the Domiciliary Care for Homeless Veterans Program and one resident room on the Substance Abuse Treatment Unit contained unsecured medications.	**10.** We recommended that Domiciliary Care for Homeless Veterans Program and Substance Abuse Treatment Unit managers ensure residents secure medications in their rooms and monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Coatesville/542) FY 2016 through December 2015	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$30.5
Number of:	
• **Unique Patients**	9,965
• **Outpatient Visits**	42,089
• **Unique Employees**[1]	922
Type and Number of Operating Beds:	
• **Hospital**	28
• **Community Living Center**	169
• **MH**	195
Average Daily Census:	
• **Hospital**	12
• **Community Living Center**	73
• **MH**	72
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Springfield/542GA Spring City/542GE
VISN Number	4

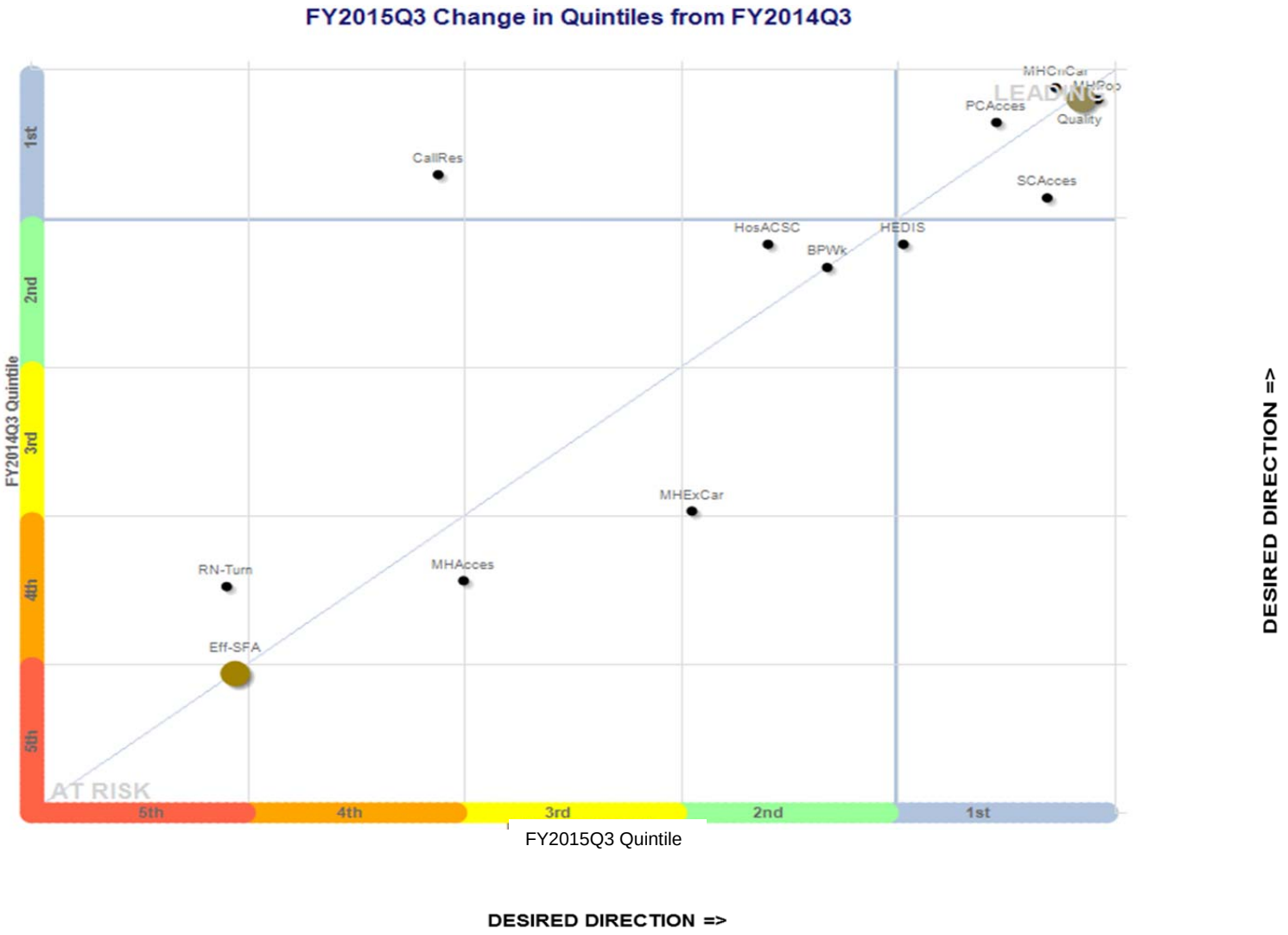
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] 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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 22, 2016

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

Subject: **OIG CAP Coatesville PA (54DC) – Draft Report and Transmittal Memo**

To: Director, Washington, DC, Regional Office of Healthcare Inspections (54DC)

Director, Management Review Service (10AR)

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

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Quality Management Officer at 412-822-3294.

(original signed by:)
MICHAEL D. ADELMAN, M.D.

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 13, 2016

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

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

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

1. I have reviewed the draft report of the Inspector General Healthcare Inspection of Coatesville VA Medical Center. I concur with the findings outlined in this report and have included the corrective action plan.

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

(original signed by:)
Gary W. Devansky
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: All but two 2015 Ongoing Professional Practice Evaluations have been completed and reviewed by each staff member. Continued compliance will be monitored through the Professional Standards Board.

Recommendation 2. We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: The Peer Review Committee will ensure actions recommended are carried out and documentation is in the Peer Review Committee minutes. Compliance will be monitored through the Annual Peer Review report.

Recommendation 3. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: As of 11/30/2015, the FY15 ePERs have been entered into SPOT. Staff have been educated about the expectation. Compliance will be monitored at 90% for 3 consecutive months and monitored in the Quality Assurance Performance Improvement Committee.

Recommendation 4. We recommended that the Patient Safety Manager submit an annual patient safety report to facility leaders at the completion of each fiscal year.

Concur

Target date for completion: March 31, 2016

Facility response: The Patient Safety Manager will have the FY15 Annual Patient Safety Report completed and submitted by March 31, 2016.

Recommendation 5. We recommended that the facility revise its protected peer review policy to be consistent with Veterans Health Administration policy and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: The Protected Peer Review Committee policy will be revised to be consistent with the Veterans Health Administration policy and documentation of process compliance will be tracked in the Peer Review Committee minutes.

Recommendation 6. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: Completed

Facility response: All damaged furniture has been removed from service.

Recommendation 7. We recommended that the facility ensure new clinical employees complete suicide risk management training within 90 days of being hired and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Suicide Prevention Coordinators (SPC) have been added to the Weekly Deficiency Report for TMS for 'Suicide Risk Management Training.' Deficiencies will be monitored per the education department SOP already in place. The SPC will review the delinquency report and contact the TMS Domain Manager to alert the second level supervisor to follow up on those provider staff who are within one week of the due date. Compliance will be monitored at 90% for 3 consecutive months in the Education and Travel Committee.

Recommendation 8. We recommended that the Power of Women Embracing Recovery Program have a Class K fire extinguisher available in the kitchen used by residents.

Concur

Target date for completion: Completed

Facility response: A Class K fire extinguisher has been made available in the kitchen on the Power of Women Embracing Recovery Program.

Recommendation 9. We recommended that Domiciliary Care for Homeless Veterans Program, Post-Traumatic Stress Disorders Residential Rehabilitation Treatment Program, and Substance Abuse Treatment Unit employees consistently perform and document contraband inspections, daily bed checks, and resident room inspections for unsecured medications and that program/unit managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: An SOP has been developed and staff have been educated. Compliance will be monitored at 90% for 3 consecutive months and be reported to the Mental Health Executive Committee.

Recommendation 10. We recommended that Domiciliary Care for Homeless Veterans Program and Substance Abuse Treatment Unit managers ensure residents secure medications in their rooms and monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Unit Managers will review the face check sheets daily to ensure rounds for unsecured medications are completed twice daily. Compliance will be monitored by the Unit Managers at 90% for 3 consecutive months and be reported to Mental Health Executive Committee.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Bruce Barnes, Team Leader Lisa Barnes, MSW Gail Bozzelli, RN Myra Conway, MS, Kay Foster, RN Donna Giroux, RN Randall Snow, JD Robert Breunig, Special Agent, Office of Investigations
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U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Ryan Costello, Charles W. Dent, Pat Meehan, Joseph R. Pitts

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

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- 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, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[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 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[h] 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.