Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-00470-172

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

June 15, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Table of Contents

Executive Summary

Introduction

During the week of March 8–12, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA New Jersey Health Care System (the system), East Orange, NJ. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 1,034 system employees. The system is part of Veterans Integrated Service Network (VISN) 3.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Moving American Veterans into Employment and Residences in the Community (MAVERIC)
- Planetree Model Implementation

We made recommendations in six of the activities reviewed; one recommendation was a repeat recommendation from the previous CAP report. For these activities, the system needed to:

- Implement a process to refer patient admission and continued stay cases that do not meet standardized criteria to a physician advisor.
- Ensure that medication reconciliation monitors are fully implemented.
- Monitor the use of the copy and paste functions in the electronic medical record and report trends to the appropriate committee.
- Fully develop physician practice evaluations and ensure that Professional Standards Board (PSB) meeting minutes reflect discussions regarding performance data.
- Maintain ventilation systems and inspect filters quarterly in all Supply, Processing, and Distribution (SPD) areas.
- Maintain required temperature and humidity levels in SPD areas and ensure that eyewash stations are tested and in proper working condition.
- Conduct semi-annual environment of care (EOC) rounds in all reprocessing areas.

- Ensure that non-VA persons entering restricted SPD areas are escorted and don appropriate personal protective equipment (PPE).
- Validate annual competencies for staff performing flash sterilization and ensure that reprocessing practices are consistent with manufacturers' recommendations and device-specific standard operating procedures (SOPs).
- Document in the electronic medical record that patients at high risk for suicide and/or families received copies of the suicide prevention safety plan.
- Ensure that magnetic resonance imaging (MRI) technologists screen all patients prior to MRI procedures and that screenings are documented in patients' medical records.
- Provide level appropriate MRI safety training, in accordance with the local SOP.
- Implement a process to monitor and evaluate inter-facility transfers.

The system complied with selected standards in the following two activities:

- EOC
- Medication Management

This report was prepared under the direction of Claire McDonald, Director, Boston Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 18–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system is comprised of two campuses located in East Orange and Lyons, NJ, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 10 community based outpatient clinics in Brick, Elizabeth, Fort Monmouth, Hackensack, Jersey City, Morristown, Newark, New Brunswick, Paterson, and Trenton, NJ. The system is part of VISN 3 and serves a veteran population of about 485,000 in 14 counties in New Jersey.

Programs. The system provides a full range of patient care services, including primary care, tertiary care, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, extended care, and homeless services. It has 381 hospital beds, 300 community living center (CLC) beds, 85 domiciliary beds, and 101 Psychiatric Residential Rehabilitation Treatment Program (PRRTP) beds.

Affiliations and Research. The system is affiliated with two of the University of Medicine and Dentistry of New Jersey Medical Schools—the New Jersey Medical School and the Robert Wood Johnson School of Medicine—and provides training for more than 400 residents, interns, and students. It also provides training for other disciplines, including general dentistry, oral surgery, podiatry, optometry, nursing, audiology, psychology, physician assistants, and social work.

In fiscal year (FY) 2009, the system's research program had 190 active research projects and a budget of $2.5 million. Important areas of research included oncology, neuroimmunology, endocrinology, human immunodeficiency virus, the War Related Illness and Injury Study Center, and a Research Enhancement Award Program for diabetes and complex chronic disease.

Resources. In FY 2009, system expenditures totaled $421 million. The FY 2010 system budget is $423 million. FY 2009 staffing was 3,183 full-time employee equivalents (FTE), including 241 physician and 603 nursing FTE.

Workload. In FY 2009, the system treated 59,145 unique patients and provided 42,339 inpatient days in the hospital; 84,632 inpatient days in the CLC units; 29,005 inpatient days in the domiciliary; and 20,813 inpatient days in the PRRTP.

The inpatient care workload totaled 5,721 discharges, and the average daily census, including CLC, domiciliary, and PRRTP patients, was 384. Outpatient workload totaled 645,840 visits.

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 CAP reviews are to:

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

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EOC
- Medication Management
- MRI Safety
- Physician Credentialing and Privileging (C&P)
- QM
- Reusable Medical Equipment (RME)
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through the 2nd quarter and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the system (*Combined Assessment Program Review of the VA New Jersey Health Care System, East Orange, New Jersey,* Report No. 06-01128-201, September 11, 2006). We found sufficient evidence that managers had implemented appropriate actions for three of the four health care recommendations, and we consider those issues closed. The fourth recommendation relating to utilization management is addressed in the QM section of this report and remains open.

During this review, we also presented fraud and integrity awareness briefings to 1,034 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.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Moving American Veterans into Employment and Residences in the Community

In response to an increasing unemployment rate in New Jersey over the past 10 years, the vocational rehabilitation division of the system's homeless services developed MAVERIC Industries to improve work opportunities for homeless veterans. Based on the skills and interests of the veterans, the system developed a café/catering service, a commercial greenhouse, and a driving range adjacent to a local municipal golf course. The businesses provide veterans with vocational training and modest income.

MAVERIC Industries enrolled 27 veterans in its first year (2000) and grew to 62 veterans by FY 2007. It currently employs more than 70 veterans, and the revenues are used to provide additional compensated work therapy throughout the system. Sixty-eight percent of the veterans who have received training through MAVERIC Industries have been able to transition into full-time competitive employment.

Planetree Model Implementation

In December 2005, the system adopted a nationally recognized patient-centered care model known as Planetree. Since its inception, teams comprised of more than 90 employees and volunteers have organized and participated in multiple activities, such as baking cookies,

harp therapy, humor day, and therapeutic touch programs, designed to incorporate the Planetree principles into the system's culture of care.

Pursuant to its focus on patient-centered care, the system performed an acoustics assessment due to complaints of high noise levels at the East Orange campus. In an effort to reduce unhealthy noise levels, the system installed a "Yacker Tracker," which lights up when noise levels exceed unhealthy decibels. The system has been successful in reducing unhealthy noise levels, and patient satisfaction scores for noise control (86 percent) currently exceed the Veterans Health Administration (VHA) target of 79 percent.

In order to keep patients and employees fully informed about Planetree activities, in June 2006, the system developed and implemented an intra-system website. In 2009, VHA awarded the system a Bronze level communications award for the system's Planetree affiliation and multimedia promotion of the website.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers, patient safety employees, and the QM coordinator.

The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following areas that needed improvement.

Utilization Management. VHA policy requires that cases not meeting the standardized criteria be referred to a physician advisor as a third-level reviewer.[1,2] Utilization management is the process of evaluating and determining the

[1] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[2] A utilization management specialist is considered the first-level reviewer, and the attending physician is considered the second-level reviewer.

appropriateness of medical care services across the continuum of care to ensure the efficient and appropriate utilization of resources. Patient admissions and continued stays are compared to standardized criteria or clinical indicators that reflect the need for hospitalization or treatment. However, we did not find evidence that patient records requiring a third-level review were consistently referred to a physician advisor. This was a repeat finding from our previous CAP review.

Medication Reconciliation. The Joint Commission (JC) requires that medications be accurately and completely reconciled across the continuum of care. This process ensures that patients and clinicians are aware of medication changes when a patient is transferred from one setting, service, provider, or level of care to another within or outside the system. A complete list of the patient's medications is compared (reconciled) with the list of medications at the next level of care. We did not find evidence that the system had ongoing monitors to ensure compliance, as required.

Medical Record Documentation. VHA policy requires that managers monitor the copy and paste functions in the electronic medical record for inappropriate use and report violations to the Medical Staff Committee for corrective actions.[3] While VHA requirements for monitoring have been in place since 2006, system managers did not begin monitoring the use of these functions until January 2010. Consequently, insufficient data has been collected to allow for trending.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires managers to implement a process to refer patient admission and continued stay cases that do not meet standardized criteria to a physician advisor.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that medication reconciliation monitors are fully implemented, as required.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires managers to monitor the use of the copy and paste functions in the electronic medical record and report trends to the appropriate committee.

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

The VISN and the System Directors agreed with the findings and recommendations and reported that the supervisory QM specialist has reviewed the requirement to refer all cases that do not meet utilization criteria to the physician advisor with staff who are completing the reviews. In the future, the automated utilization review system will electronically notify physician advisors. In the interim, QM reviewers are contacting physician advisors and logging interactions.

A team is refining the medication reconciliation process at discharge so that patients get one concise, accurate list of their medications. Additionally, the system began monitoring the copy and paste functions during the 2nd quarter of FY 2010, and the first report was presented to the Medical Record Committee in March. The system will continue monthly auditing. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[4] We also reviewed PSB meeting minutes during which discussions about the physicians took place.

We reviewed C&P files and profiles for 14 physicians who were either appointed to the medical staff or reprivileged in the past 12 months. We found that licenses were current and that primary source verification was obtained.[5] However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA policy requires specific competency criteria for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. Although clinical managers had developed service-specific criteria for practice evaluations, at the time of our review, they had not been developed for all physicians. As a result, we did not find an FPPE for one physician who had requested additional privileges and one physician who had a change in condition that may have affected that physician's

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[5] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

ability to perform the requested privileges. In addition, we did not find OPPEs for 6 (50 percent) of the 12 physicians who were reprivileged. Furthermore, PSB meeting minutes did not reflect detailed discussions of physicians' performance data prior to granting privileges or reprivileging, as required by VHA policy.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that clinical managers fully develop practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting requested privileges or reprivileging.

The VISN and the System Directors agreed with the findings and recommendations and reported that the Chief of Staff and Director of QM have agreed to standardize the template used for OPPE to be consistent with VHA guidelines. Services will be provided with content requirements in June so that they can begin drafting new profiles to be presented for approval during July and August. In addition, medical staff are reviewing FPPE formats that will be used for new providers, for any change in a provider's condition that may affect privileging, and for requests for new privileges. Full implementation is targeted for September 2010.

PSB meeting minutes will be revised to ensure that appropriate content is captured to reflect the deliberative process of reviewing and appointing providers. A draft format will be tested in June, revised, and fully implemented in July 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system had processes in place to ensure effective reprocessing of RME. Improperly reprocessed RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The system's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and JC standards.

At the East Orange campus, we inspected SPD, the endoscopy reprocessing area, and an SPD satellite

reprocessing area. At the Lyons campus, we inspected SPD and the gastrointestinal (GI) clinic reprocessing area.

VA policy requires that negative pressure is maintained in "dirty" areas, such as the decontamination area of SPD, in order to minimize the movement of microorganisms from dirty to clean areas.[6] An August 2009 pressure differential analysis report for the decontamination area in SPD at the Lyons campus showed two areas of positive air flow rather than complete negative air flow. System staff did not correct the air flow for almost 8 months despite a second report in January 2010 with the same finding and a recommendation for adjustment and re-testing. System staff corrected this air flow issue while we were onsite; therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

Air Flow. VA policy requires that Engineering Service maintain the ventilation system and inspect filters in SPD at least quarterly.[7] We found documentation that filter inspections were performed as required at the East Orange campus. However, at the Lyons campus, we found no documentation of inspections and/or filter changes in calendar year 2009.

Environmental Conditions. VA policy requires that temperature and humidity levels in all SPD areas be maintained within specific ranges.[8] We found humidity levels in three SPD areas below the specified range and the temperature level in one of the three areas above the specified range. Staff were not fully knowledgeable about normal ranges and had not reported out-of-range levels. Additionally, we did not find consistent documentation of temperature and humidity levels in two of the three areas.

VHA policy requires employees who work in areas where emergency eyewash stations are located to be trained in the proper operation and effective use of the equipment.[9] We found eyewash stations in the reprocessing areas, but staff were not fully knowledgeable about properly testing the stations or assessing the force of the stream when the

[6] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirement;* August 16, 2002.
[7] VA Handbook 7176.
[8] VA Handbook 7176. Temperature should be maintained between 65 and 72 degrees Fahrenheit, and the humidity should be maintained between 35 and 75 percent.
[9] VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment;* May 13, 2009.

eyewash stations were activated. Two of the eyewash stations' water streams were so forceful that their catch basins quickly overflowed when activated for just a few seconds. Water streams in other eyewash stations appeared very weak and may have been inadequate in an emergency. Also, staff could not produce documentation of consistent testing of eyewash stations and reported that because of basin overflow, some eyewash stations were not tested in accordance with local SOPs.

Additionally, VHA requires semi-annual EOC rounds to be conducted in all areas within the facility.[10] A local monitoring plan requires EOC rounds twice a year to "centralized and outside of SPD reprocessing areas." In calendar year 2009, semi-annual rounds were conducted in reprocessing areas at the Lyons campus, but at the East Orange campus, rounds in the operating room, SPD, and the GI clinic were conducted only once.

SPD Access and PPE. VA policy requires that access to SPD be restricted to authorized persons only. A VA supervisor or designee must escort non-VA personnel who enter the area.[11] All persons entering decontamination areas must don appropriate attire, including face shields or safety goggles with surgical face masks. In the SPD decontamination area at the Lyons campus, two signs addressing PPE gave inconsistent information regarding masks and goggles. System managers removed the incorrect sign while we were onsite. However, before the sign was removed and while we were conducting an inspection in the area, an unescorted, non-VA delivery person entered the decontamination area without appropriate PPE. It was apparent by a comment the delivery person made when instructed on appropriate PPE that the individual had previously accessed the decontamination area without appropriate PPE.

Reprocessing. VHA policy requires that personnel involved with the use and reprocessing of RME have documented initial training on the set-up, use, reprocessing, and maintenance of the specific RME and have validation of that competency annually.[12] We reviewed the competency

[10] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March5, 2007.
[11] VA Handbook 7176.
[12] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

folders of 10 operating room staff and found that annual competencies for flash sterilization had not been completed.

VHA policy also requires that RME reprocessing SOPs reflect manufacturer recommendations, are available in the reprocessing area, and are followed.[13] We observed the reprocessing of 10 pieces of RME. In one instance, staff failed to follow the manual cleaning instructions recommended by the manufacturer and the SOP, and in another instance, staff used an incorrect brush during manual cleaning.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires Engineering Service to maintain ventilation systems and inspect filters quarterly in all SPD areas.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires managers to maintain required temperature and humidity levels in all SPD areas and ensure that all emergency eyewash stations are tested in accordance with local policy and are in proper working condition.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires managers to conduct semi-annual EOC rounds in all reprocessing areas.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that non-VA persons entering restricted SPD areas are escorted and don appropriate PPE.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires managers to validate annual competencies for staff performing flash sterilization and ensure that reprocessing practices are consistent with manufacturers' recommendations and device-specific SOPs.

The VISN and the System Directors agreed with the findings and recommendations and reported that a system memorandum dated May 6, 2010, reinforces requirements for quarterly maintenance of the ventilation system and inspection of air filters in all SPD areas. In addition, the system has standardized the requirement for temperature

[13] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

and humidity monitoring in all SPD areas and is in the process of writing a memorandum that will include actions to be taken when temperature or humidity is out of range.

The system is currently in the process of inspecting every eyewash station to ensure that they are functioning properly. It is also revising local policy to include a clear process for testing eyewash stations. The Safety Officer will coordinate biannual inspections to verify that weekly testing is occurring. Findings will be reported to the EOC Committee.

The system has also established an annual calendar that includes all reprocessing areas in semi-annual EOC rounds. QM staff will monitor quarterly to verify that inspections occur as scheduled. Results will be reported to the EOC Committee and the system's Director.

The requirements for non-VA persons who enter restricted SPD areas have been reviewed with all SPD staff. The system has also ordered standardized signage so that these instructions are clear.

Annual competencies for flash sterilization have been developed, and all required staff have documented competencies in place. Staff will be required to follow the step-by-step procedures for reprocessing. In addition, random observations by SPD and QM staff have been implemented to ensure that proper procedures are being followed. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety

plan development.[14] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of 10 patients assessed to be at high risk for suicide and identified the following area that needed improvement.

Safety Plans. Patients at high risk for suicide are required to receive a copy of the written safety plan.[15] In 9 (90 percent) of the 10 records reviewed, we found that clinicians did not document on the suicide prevention safety plan that patients and/or their families were provided copies of the plan.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires clinicians to document in the electronic medical record that patients at high risk for suicide and/or their families received copies of the safety plan.

The VISN and the System Directors agreed with the finding and recommendation and reported that an item has been added to the suicide prevention safety plan to confirm that the patient and/or family member received a copy of the plan. To ensure full compliance, the system will include this item in medical record reviews for the remainder of the year. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[15] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area, and patients in Zone IV (the magnet room) are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a call system while in the scanner. We identified two areas that needed improvement.

Patient Screening. All patients should undergo safety screening prior to MRI procedures.[16] We reviewed the medical records of 10 patients who underwent MRI procedures during the month of December 2009 to determine whether MRI technologists conducted required screenings. Although MRI technologists reported screening all patients, they did not document screenings in patients' medical records.

MRI Safety Training. The local MRI safety SOP requires the Radiation Safety Officer or the MRI Safety Officer to provide annual MRI safety training to Level 1 and Level 2 MRI personnel, designated nursing personnel, and the radiologist.[17] In addition, Level 2 personnel must receive further supplemental annual training and be certified in Basic Life Support (BLS). According to the SOP, personnel are not permitted into Zones II, III, and IV without appropriate training and screening.

We reviewed the training records of six Level 1 MRI personnel and found that five of the six did not consistently receive annual MRI safety training. We reviewed the training records of six Level 2 MRI personnel and found that all six were BLS certified. However, three of the six did not consistently complete annual MRI safety training, as required. In addition, MRI technologists did not receive Level 2 training prior to March 2010, and we could find no documentation of Level 2 training of appropriate nursing personnel. Also, we could not validate that one MRI technologist received MRI safety training prior to accessing Zones II, III, and IV.

[16] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Sec. 4.3, MRI Safety.

[17] There are two levels of MRI personnel. Level 1 MRI personnel are those who have passed minimal safety educational efforts to ensure their own safety. The local SOP defines Level 1 MRI personnel as those with access to Zone III and may include police or housekeeping staff. Level 2 MRI personnel, such as MRI technologists, are those who have been more extensively trained and educated in the broader aspects of MRI safety issues.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that MRI technologists screen all patients prior to MRI procedures and that these screenings are documented in patients' medical records.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires the Radiation Safety Officer or the MRI Safety Officer to provide level appropriate MRI safety training, in accordance with the local SOP.

The VISN and the System Directors agreed with the findings and recommendations and reported that all MRI patient screening assessments are now scanned and available as a part of the patient's medical record. Additionally, all staff who work in MRI have completed Level 2 training. As of May 6, 2010, 73 percent of general staff who may need to access the MRI suite have completed Level 1 training. The Radiation Safety Officer and MRI Safety Officer will track this training to completion. The corrective actions are acceptable, and we consider these two recommendations closed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that health care systems have a policy to ensure the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program.[18] Our review of transfer documentation for 10 patients found that the system had an appropriate transfer policy and that system staff were following the policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. The system had not implemented procedures to monitor and evaluate patient transfers as part of the QM program. System staff acknowledged that while they recorded transfer information on a spreadsheet, they had not implemented any further monitoring procedures to

[18] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

ensure that transfers were appropriate and timely or conducted in accordance with VHA requirements.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires managers to implement a process to monitor and evaluate inter-facility transfers, in accordance with VHA policy.

The VISN and the System Directors agreed with the finding and recommendation and reported that the system will begin monitoring and evaluating inter-facility transfers in May. Results will be reported to the Medical Record Committee as a component of medical record review. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

At the East Orange campus, we inspected the dialysis unit, the emergency department, the surgical unit, the intensive care unit, the inpatient mental health unit, the dental clinic, and one specialty clinic. At the Lyons campus, we inspected one primary care clinic, one CLC unit, two inpatient mental health units, and the residential post-traumatic stress disorder unit.

The system maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. We made no recommendations.

Medication Management

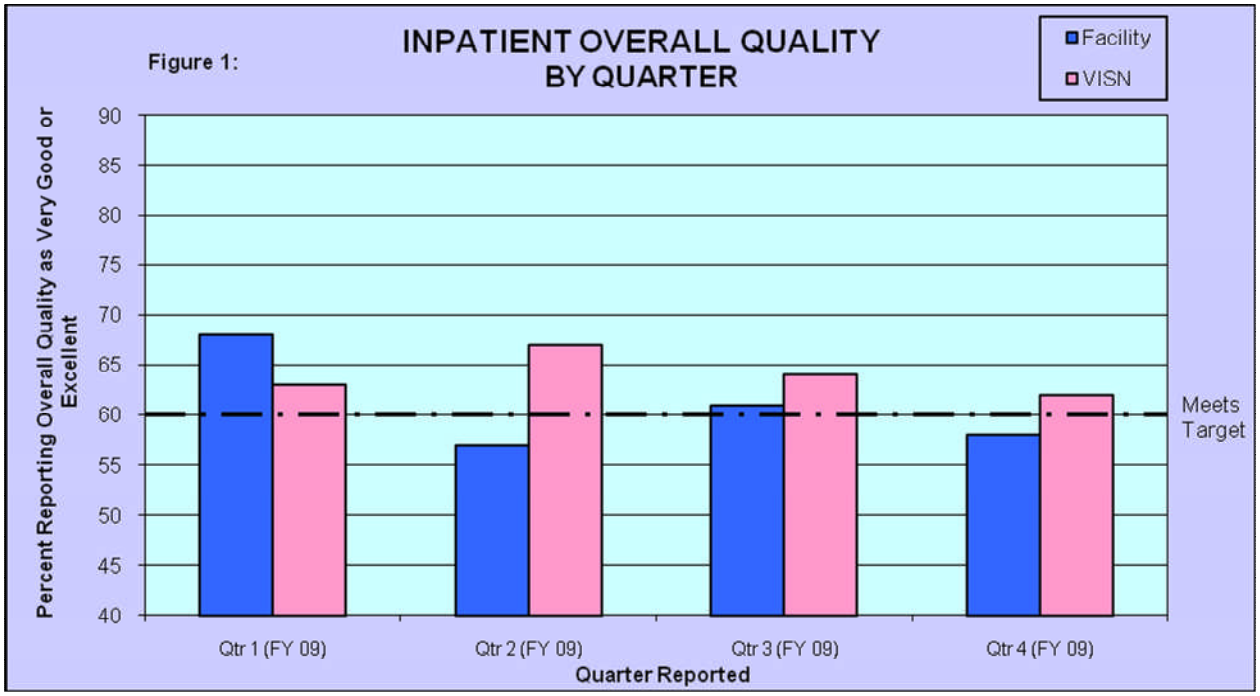
The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The system utilizes a VISN 3 practice guideline that governs the maintenance of chronic renal disease patients who

receive erythropoiesis-stimulating agents.[19] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. We made no recommendations.

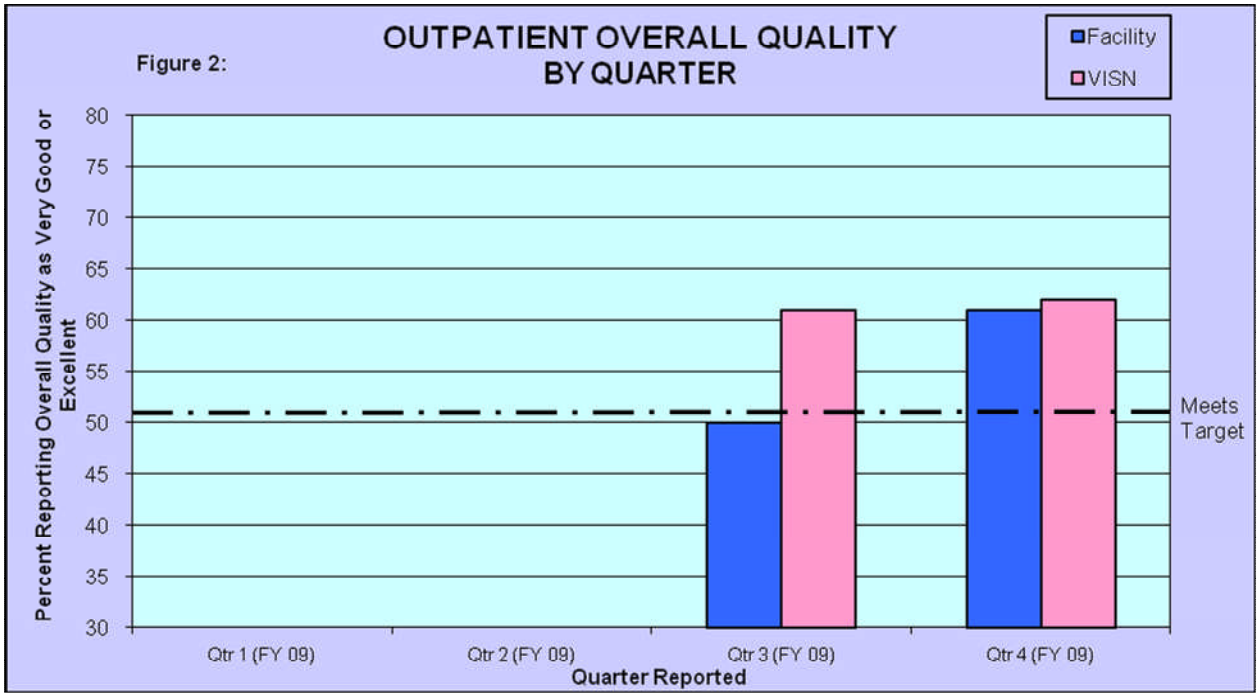
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[20] The target scores are noted on the graphs.

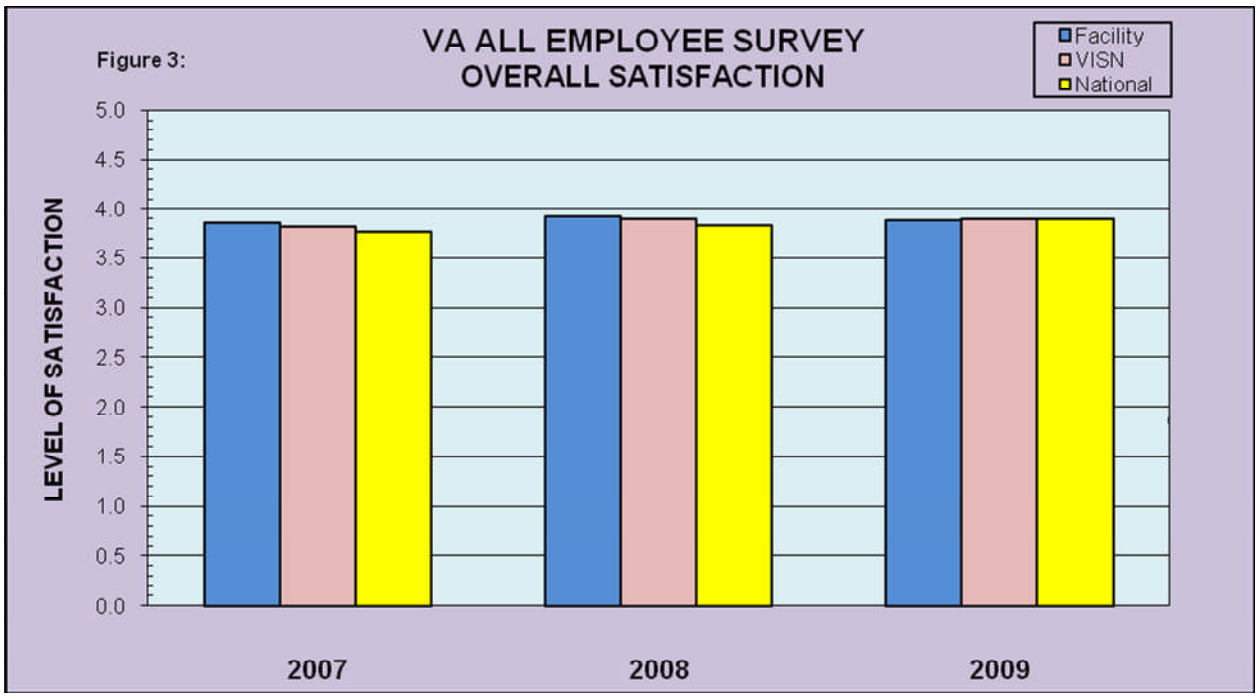


[19] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

[20] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2010

From: VISN Director

Subj: **Combined Assessment Program Review of the VA New Jersey Health Care System, East Orange, NJ**

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

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the results of the OIG Combined Assessment Program Review of the VA New Jersey Health Care System, East Orange, NJ and the New Jersey action plans developed and concur with all findings and recommendations.

Thank you for your comprehensive review of our programs.

Michael A. Sabo, Director
VA New York/New Jersey Veterans Healthcare Network

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 5, 2010

From: System Director

Subj: **Combined Assessment Program Review of the VA New Jersey Health Care System, East Orange, NJ**

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

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the attached report of the Combined Assessment Program Review of the VA New Jersey Health Care System and concur with the findings and recommendations. Attached are our comments and action plans for each recommendation.

On behalf of the entire VA New Jersey Healthcare System, I would like to thank the Office of Inspector General Boston Office of Healthcare Inspections for the professionalism and thoroughness with which they carried out this review. We are mutually committed to insuring the highest quality of care for the veterans. This review assists us as we strive to meet that goal.

Original signed by:

Kenneth H. Mizrach, Director
VA New Jersey Healthcare System

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires managers to implement a process to refer patient admission and continued stay cases that do not meet standardized criteria to a physician advisor.

Concur Implementation Date: Completed

The supervisory QM specialist has reviewed the requirement to refer all cases that do not meet utilization criteria to the physician advisor with the staff who are completing the reviews. With the roll out of National Utilization Management Integration (NUMI), the VHA automated utilization review system; physician advisors will automatically be notified electronically. The system will provide reports that document the process. That system is currently being implemented nationally and has been delayed due to technical reasons. At this time we do not have a date for resolution. In the meantime, the QM reviewers are making phone or face to face contact with the physician advisors and are logging that interaction. The Supervisory QM Specialist will review the logs weekly to insure that the process is being followed and will provide monthly reports to the Director of QM on the percent of cases that do not meet criteria who are referred to the physician advisor. Once NUMI is functional, the physician advisor referral will be automatic and NUMI will capture results.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that medication reconciliation monitors are fully implemented, as required.

Concur Implementation Date: July 2010

The VANJHCS acknowledges the importance of accurately and completely reconciling patient medications. The priority opportunity for improvement, as noted by the survey, is the need to standardize and insure consistency of the medication reconciliation process at discharge so that patients get one concise, accurate list of their medications. A team lead by pharmacy is refining the process to be consistent with JC standards which have been revised effective July 1, 2010. A monitor reflecting the percent of discharged patients who have appropriate medication reconciliation at the time of discharge will be initiated with July

discharges and reported to the pharmacy and therapeutics committee, who in turn will summarize at the Executive Committee of the Medical Staff.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires managers to monitor the use of the copy and paste functions in the electronic medical record and report trends to the appropriate committee.

Concur Implementation Date: Completed

Monitoring of the copy paste function began during the second quarter FY 2010, with the first report presented to the Medical Record Committee on March 3, 2010. Monthly auditing will continue with Medical Record Committee oversight.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that clinical managers fully develop practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting requested privileges or reprivileging.

Concur Implementation Date: September 2010

FPPE formats are under review by the medical staff and have a targeted completion date of September 2010. These formats will be used to evaluate new providers, a change in a provider's condition that may affect his or her ability to perform requested privileges, or when existing providers request new privileges.

The Chief of Staff and Director of QM have agreed to standardize the template used for OPPE consistent with VHA guidelines as outlined in the DUSHOM Memorandum. Services will be provided with content requirements in June to begin drafting new profiles to be presented for approval during July and August. Full implementation is targeted for September 2010. PSB minutes will be revised to insure that appropriate content is captured to reflect the deliberative process of reviewing and appointing providers. The C&P coordinator has reached out to other facilities to obtain best practices. She has identified appropriate language to be used that reflects the process. Workload is being analyzed to determine who best can capture minutes. A draft format will be tested during June, revised and fully implemented beginning in July 2010.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires Engineering Service to maintain ventilation systems and inspect filters quarterly in all SPD areas.

Concur Implementation Date: July 2010

Requirements for quarterly maintenance of the ventilation system and inspection of air filters in all SPD areas have been reinforced by Facility Memorandum dated May 6th, 2010 signed by the Associate Director. Reports will be submitted from Facilities Management Service to both the RME Committee and the EOC Committee. To monitor compliance over the next 12 months, minutes will be reviewed by QM and a report will be submitted to the Associate Director confirming compliance.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires managers to maintain required temperature and humidity levels in all SPD areas and ensure that all emergency eyewash stations are tested in accordance with local policy and are in proper working condition.

Concur Implementation Date: July 2010

The requirement for temperature and humidity monitoring in all SPD areas has been standardized. A Facility MCM is being written to include actions to be taken when temperature or humidity is out of range (due date June 2010). Facilities Management Service (FMS) is being directed to complete an assessment of potential causes for areas out of range and implement corrective action. This assessment is due by June 30. If an area is persistently out of range and FMS cannot determine the cause, an evaluation by an outside consultant will be requested. Reports will be submitted to both the RME Committee and the EOC Committee.

The VANJHCS is currently in the process of inspecting every eyewash station to insure that it is functioning properly. This is due to be completed by the end of May. The facility policy (EC-83) is being revised to include a clear step-by-step process for testing eyewash stations to facilitate compliance by front line staff (due by the end of June 2010). Once the policy is finalized staff in all areas will be re-instructed on the proper testing procedure (by the end of July 2010.) Beginning with the last quarter of this year, the Safety Officer will coordinate biannual inspections to review that weekly testing is in fact occurring as required. These findings will be reported to the EOC Committee.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires managers to conduct semi-annual EOC rounds in all reprocessing areas.

Concur Implementation Date: September 2010

The VANJHCS has established an annual calendar that insures that all reprocessing areas are included in semi-annual EOC rounds (completed.) A specific monitor will be conducted by QM staff quarterly beginning in the 4th quarter to insure that inspections occur as scheduled per the calendar.

This report will be submitted to the EOC committee and the System Director.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that non-VA persons entering restricted SPD areas are escorted and don appropriate PPE.

Concur Implementation Date: June 2010

The requirement for non-VA persons who enter restricted SPD areas has been reviewed with all SPD staff including the need to utilize full PPE and the need to be escorted the entire time they are in the SPD area consistent with hospital policy. Standardized signage has been ordered so that these instructions are clear and are due to be installed by the end of May 2010. A line item will be added to the existing Quality Monitor to incorporate random spot checks as part of routine monitoring. This will be reported at the RME Committee beginning with the June 2010 meeting.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires managers to validate annual competencies for staff performing flash sterilization and ensure that reprocessing practices are consistent with manufacturers' recommendations and device-specific SOPs.

Concur Implementation Date: Completed

Annual competencies for flash sterilization have been developed and 100 percent of required staff has documented competencies in place. All staff are required to follow the detailed step by step procedures for reprocessing. Of the two deviations that were noted by the surveyors, one involved the use of a brush for cleaning that was a 'hard' bristle as opposed to a 'soft' bristle. This occurred because there was only one type of brush available at the time. This has been corrected. The second deviation involved a staff member who used a disinfectant sponge instead of mixing the solution as per procedure to soak the instrument (both are the same product). This reflected an individual whose performance deviated from the standardized process. The staff member involved was re-educated and has been observed to now be following the procedure correctly. In addition, random observations by SPD as well as QM staff have been implemented to insure and reinforce that proper standardized procedures are being followed.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires clinicians to document in the electronic medical record that patients at high risk for suicide and/or their families received copies of the safety plan.

Concur Implementation Date: Completed

As recommended during survey, an item has been added to the Suicide Prevention Safety Plan that confirms that the patient and/or family member received a copy of the plan (completed.) To insure full compliance this item will be included in Medical Record Review for the remainder of this year.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires that MRI technologists screen all patients prior to MRI procedures and that these screenings are documented in patients' medical records.

Concur Implementation Date: Completed

All MRI patient screening assessments are now scanned into CPRS VISTA Imaging, and are available as a part of the patient's medical record.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires the Radiation Safety Officer or the MRI Safety Officer to provide level appropriate MRI safety training, in accordance with the local SOP.

Concur Implementation Date: August 2010

As per ACR guidelines and facility SOP, all staff who work in MRI must have Level 2 training. This training has been completed for all MRI staff. Any general staff who may need to access the MRI suite (including clinical, FMS, environmental management service, police, etc) must have Level 1 training. As of May 6, 2010, 73 percent of these staff members have completed Level 1 training. The remaining staff members will complete this training by July 30, 2010. The Radiation Safety Officer/MRI Safety Officer will track to completion. It should be noted that all staff are screened prior to entering the MRI suite and informal education is provided at that time (why they are being screened and what the safety hazard is).

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires managers to implement a process to monitor and evaluate inter-facility transfers, in accordance with VHA policy.

Concur Implementation Date: July 2010

The monitoring and evaluation of inter-facility transfers will commence effective with May transfers and will be reported to the Medical Record Committee as a component of routine Medical Record Review.

OIG Contact and Staff Acknowledgments

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