Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-02991-96

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

February 23, 2011

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 crime awareness briefings 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.

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

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CRC	community residential care
EOC	environment of care
facility	Coatesville VA Medical Center
FY	fiscal year
JC	Joint Commission
MDRO	multidrug-resistant organisms
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
QM	quality management
UC	urgent care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, PA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of November 15, 2010.

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

- Coordination of Care
- Quality Management

The facility's reported accomplishments were the receipt of a Gold Cornerstone Award for patient safety and the production of a quick reference tri-fold for emergency preparedness.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Conduct a comprehensive inspection of the facility, and take action to correct deficiencies related to patient safety, fire safety, general cleanliness, and maintenance. Complete and document N95 respirator fit testing and training for appropriate personnel.

Physician Credentialing & Privileging: Strengthen processes to ensure that privilege documentation and approval comply with Veterans Health Administration requirements.

Management of Test Results: Communicate normal test results to patients within the specified timeframe.

Management of Multidrug-Resistant Organisms: Ensure employees receive annual multidrug-resistant organism education that includes training on the color-coded isolation precautions, and consistently document the training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 administration and QM.
- 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

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through November 15, 2010, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, Pennsylvania,* Report No. 08-01089-137, June 4, 2008). The facility provided

sufficient proof that it had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 332 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.

Reported Accomplishments

Gold Cornerstone Award

The facility received a Gold Cornerstone Award from the National Center for Patient Safety for the quality and number of root cause analyses completed during FY 2010.

Quick Reference Tri-folds

The facility produced quick reference tri-folds for emergency preparedness and placed them at critical access points throughout the facility.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the locked MH, acute medical, and CLC units. We also inspected Physical Medicine and Rehabilitation Service, Radiology Service, primary care outpatient clinics, and the UC clinic. The facility maintained a generally safe environment.

The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. We found that some chairs in the UC clinic waiting room were too close to the reception desk to ensure auditory privacy for patients checking in. Staff immediately moved the chairs away from the reception desk while we were onsite. Therefore, we made no recommendation for this finding. However, we identified the following conditions that needed improvement.

Patient Safety. VHA requires that locked inpatient MH units be free of objects that could serve as anchor points for hanging.[1] During our inspection of the locked MH unit, we identified the following hazards:

- Some door closure mechanisms
- Two payphones with cord lengths that exceeded 12 inches
- A shower safety grab bar
- A patient room door handle

While we were onsite, the facility devised a plan to address the hazards temporarily while pursuing options for a permanent solution.

Fire Safety. National Fire Protection Association standards require that corridors be clear of obstructions in the event that emergency evacuation is required. We found medical equipment stored in a CLC hallway that reduced the corridor width to less than 6 feet and blocked the egress to an exit door. We also found the egress to a fire exit in the UC clinic obstructed.

General Cleanliness and Maintenance. The JC requires that areas used by patients be clean. During our inspection of patient care areas, we noted general cleanliness and maintenance conditions needing improvement. In most areas, including housekeeping and utility closets, we found dirt and debris on floors, along baseboards, and in corners. Dust accumulation was visible on sprinkler heads, on air ventilation system covers, and on unsecured uninterruptible power supply units on the floor. We also observed holes in walls, stained ceiling tiles, warped walls, and buckled floor tiles in multiple areas.

Two patient showers on the locked MH unit were in need of deep cleaning. We found a soiled shower curtain and evidence of live insects. Staff took immediate action to correct these deficiencies. We reinspected the shower area the next day and found it to be clean; however, ongoing monitoring of the area is needed.

N95 Respirator Fit Testing.[2] OSHA standards require designated staff to be fit tested and trained for respirator use

[1] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," November 1, 2010.
[2] An N95 respirator mask provides protection through a tight facial seal and 95 percent filter efficiency. Although the "N" means "not resistant to oil," they are fluid resistant.

as part of a complete respiratory protection program. We reviewed 10 employee training records and determined that only 5 (50 percent) of the designated employees had received the required annual fit testing or training.

Recommendations

1. We recommended that a comprehensive EOC inspection of the facility be conducted and that appropriate actions be taken to correct identified deficiencies related to patient safety, fire safety, general cleanliness, and maintenance.

2. We recommended that annual N95 respirator fit testing and training be completed and documented for all designated employees.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 12 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Privileges. VHA requires that privileges granted to a physician be time-limited and specific to the facility, service, setting, and provider.[3] We reviewed the records of 12 privileged physicians and found only 3 (25 percent) records without irregularities. Examples of irregularities included forms with missing or illegible documentation regarding the specific setting, service, or timeframe for privileges requested. Additionally, one physician was granted privileges when a required certification was in a pending status.

Recommendation

3. We recommended that processes be strengthened to ensure that privilege documentation and approval comply with VHA requirements.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[4]

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[4] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal test results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[5] We reviewed the medical records of 20 patients who had normal results and found that only 12 (60 percent) records contained documented evidence that the facility had communicated the results to the patients.

Recommendation

4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

We inspected the CLC (1BNH & 59B) and domiciliary (8BDOM) units, interviewed six employees, and reviewed medical records and employee training records. We identified no deficits in either the inspections or the medical records. However, we identified the following area that needed improvement.

Employee Training. The JC requires that facilities conduct a risk assessment to determine the need for staff education. The facility's most recent risk assessment stated that education was indicated for all employees during orientation and annually thereafter. The facility has a color-coded system in which colored dots are used outside patients' rooms to identify precautions appropriate to the type of isolation. We reviewed 10 employee-training records and found only 1 (10 percent) record with documentation regarding the color-coded isolation precautions. Additionally, we interviewed six employees, and none could state the isolation precautions related to the color codes.

Recommendation

5. We recommended that employees receive annual MDRO training that includes the color-coded isolation

[5] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

precautions and that the training be consistently documented.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed patients' medical records and determined that the facility generally met requirements in these areas. We made no recommendations**.**

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 11–14, for the full text of the Directors' comments.) We consider Recommendation 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[6]		
Type of Organization	Specialty referral	
Complexity Level	3	
VISN	4	
Community Based Outpatient Clinics	Spring City, PA Springfield, PA	
Veteran Population in Catchment Area	373,738	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Program**	306	
• **CLC/Nursing Home Care Unit**	169	
•		
Medical School Affiliation(s)	Drexel University	
• **Number of Residents**	6	
	FY 2010	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$174	$172
• **Medical Care Expenditures**	$138	$171
Total Medical Care Full-Time Employee Equivalents	1,321	1,302.4
Workload:		
• **Number of Station Level Unique Patients**	19,077	19,007
• **Inpatient Days of Care:**		
o **Acute Care (Medicine)**	163	225
o **Acute Care (Psychiatry 58B)**	8,721	10,552
o **CLC/Nursing Home Care Unit**	47,676	48,047
Hospital Discharges	2,847	2,961
Total Average Daily Census (including all bed types)	409	405
Cumulative Occupancy Rate	86%	85%
Outpatient Visits	169,530	175,309

[6] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
CRC Program			
1. Ensure that visits to CRC program homes are documented in the electronic medical record.	Visits are being documented in the electronic medical record.	Y	N
2. Ensure that the CRC Coordinator updates the CRC handbook annually and meets with CRC home operators annually to review the handbook and that these meetings are documented in the electronic medical record.	The handbook is updated annually, and the Coordinator meets with home operators annually.	Y	N
3. Ensure that the CRC Coordinator meets annually with VA Regional Office fiduciaries to discuss CRC residents and documents the meetings in the electronic medical record.	The CRC Program Coordinator coordinates this on an annual basis.	Y	N
QM			
4. Require the Peer Review Committee to meet at least quarterly.	Meetings are held every quarter.	Y	N
Pharmacy Operations			
5. Require that annual training for controlled substances inspectors is conducted and documented.	This has been conducted and documented.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
6. Require that all designated EOC team members participate in all EOC rounds and that documentation of participation is complete.	The EOC rounds policy has been revised to include required members and invited guests.	Y	N
7. Comply with VHA policy regarding security measures for protection of research animals.	The Research Associate Chief of Staff reviews and initials the sign-in sheets to ensure everyone is signing in and out of the building.	Y	N
8. Ensure compliance with VHA patient safety standards for training of locked MH unit staff and MSIT members. Ensure that the MSIT includes the appropriate disciplines.	MH EOC training is now recorded in the Learning Management System. There is a sign-in sheet for the rounds that includes the appropriate membership.	Y	N
9. Require appropriate staffing of the UC clinic during all hours of operation.	The UC clinic has 24/7 nursing staff.	Y	N

VHA Satisfaction Surveys

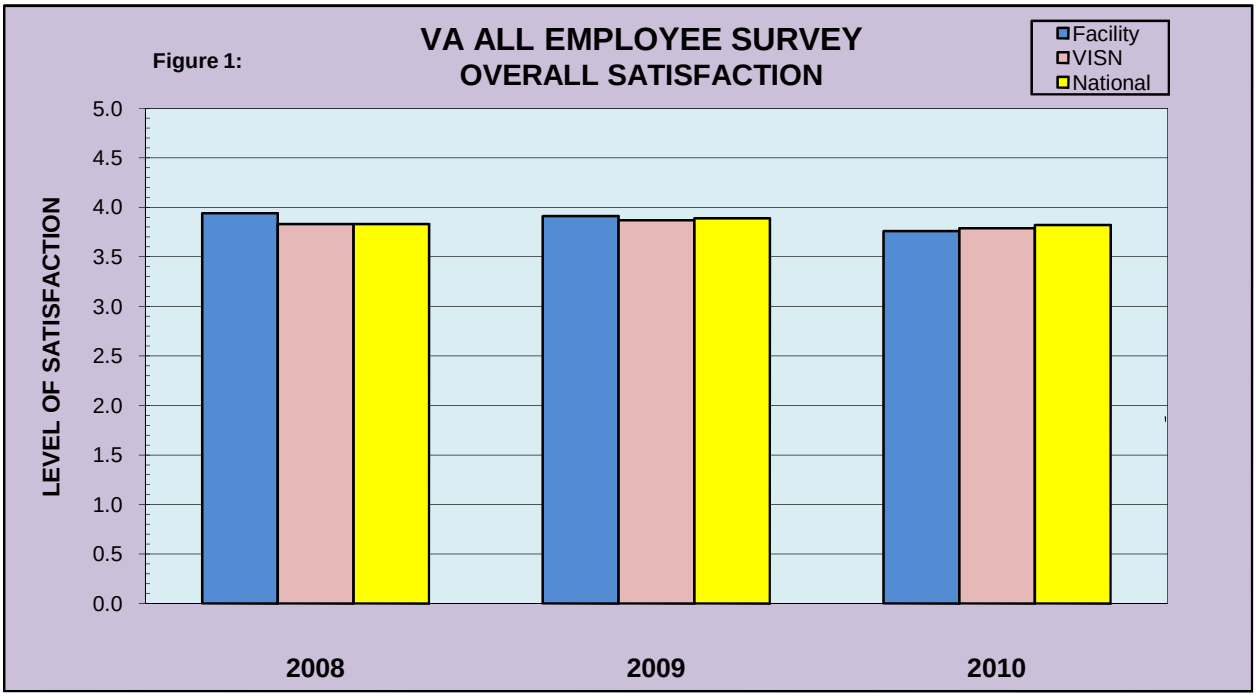
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	*	*	*	64.6	70.4	65.7
VISN	62.7	65.5	65.3	59.5	61.4	60.1
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



* Not reported. Less than 30 responses.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 4, 2011

From: Director, VISN 4 (10N4)

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

To: Director, Baltimore Healthcare Inspections Division (54BA)

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

1. I have reviewed the submitted responses and concur with the findings and recommendations.

(original signed by:)
MICHAEL E. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 3, 2011

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

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

To: Director, VISN 4 (10N4)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Coatesville VA Medical Center. We concur with the findings and recommendations.

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

(original signed by:)
Gary W. Devansky

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 a comprehensive EOC inspection of the facility be conducted and that appropriate actions be taken to correct identified deficiencies related to patient safety, fire safety, general cleanliness, and maintenance.

Concur

Target date for completion: August 31, 2011

Action Plan: This will be included in our weekly EOC rounds with an emphasis on completing all of the deficiencies as soon as possible. EOC rounds are conduct every Friday and it takes 6 months to do the entire facility once. This includes all areas, clinical and administrative. A report will be sent quarterly to Executive Leadership Council for review and recommendations.

Recommendation 2. We recommended that annual N95 respirator fit testing and training be completed and documented for all designated employees.

Concur

Target date for completion: March 31, 2011

Action Plan: Current roster has been updated. The Safety Officer will ensure that all staff fit testing is current. Area Business Managers send current staff roster to the Safety Officer monthly. New staff are immediately added to the fit testing roster and fit tested. Fit test data is recorded in Occupational Health Recording System, Porta Count machine data base, and a hard copy certificate is kept in the Safety Office. Current compliance rate is 8 percent.

Recommendation 3. We recommended that processes be strengthened to ensure that privilege documentation and approval comply with VHA requirements.

Concur

Target date for completion: Completed.

Action Plan:

- Any response, from an institution where a prospective appointee has practiced, that does not contain information about specific privilege competence, will be followed by a written request specifying what information is still needed.

- Every ongoing professional practice evaluation will contain the provider names and review period dates.
- The Position Standard Board's use of ongoing professional practice evaluation information will be sufficiently documented in each set of minutes in which a re-privileging action is described.
- All handwritten amendments/corrections to privileging applications will be dated and initialed.
- Privileges that depend on a soon-to-be-completed certification will not be included in the privilege request until the certification is achieved.

Recommendation 4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: Completed

Action Plan: Providers were reeducated on the process to inform patients of normal test results. Process developed to consistently monitor communication of test results to patients. Monitoring was implemented December 1, 2010. This data is reported in the Primary Care Quarterly report. This report is reviewed by the Primary Care Executive Council and the Administrative/Clinical Operations Management Board. A random review of December and January notifications revealed 100 percent compliance.

Recommendation 5. We recommended that employees receive annual MDRO training that includes the color-coded isolation precautions and that the training be consistently documented.

Concur

Target date for completion: March 31, 2011

Action Plan: Developed a Learning Management System training log to record trainings on January 3, 2011. Revise annual infection control training to include MDRO/infection prevention precaution guideline. Create a Learning Management System module on infection prevention precaution guidelines to provide hospital wide training now, annually, and in new employee orientation.

OIG Contact and Staff Acknowledgments

Contact	Judith Thomas, RN, Team Leader Baltimore Office of Healthcare Inspections
Contributors	Jennifer Christensen, DPM Myra Conway, RN Melanie Cool, RD Kimberly Pugh, RN Clarissa Reynolds, MBA Sonia Whig, RD Mark Lazarowitz, Newark Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare (10N4)
Director, Coatesville VA Medical Center (542/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr.; Patrick J. Toomey
U.S. House of Representatives: Jim Gerlach, Pat Meehan, Joseph R. Pitts, Todd Platts

This report is available at http://www.va.gov/oig/publications/reports-list.asp.