Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02712-37

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

December 6, 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.

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Glossary

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
COC	coordination of care
EN	enteral nutrition
EOC	environment of care
facility	Edith Nourse Rogers Memorial Veterans Hospital
FY	fiscal year
MH	mental health
OIG	Office of Inspector General
PR	peer review
QM	quality management
RN	registered nurse
UC	urgent care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA

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 September 12, 2011.

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

- Management of Workplace Violence
- Physician Credentialing and Privileging
- Registered Nurse Competencies

The facility's reported accomplishments were a reduction in the length of inpatient psychiatric stays and being a national model for the VA peer service program.

Recommendations: We made recommendations in the following four activities:

Coordination of Care: Update facility policy to include advance directive training requirements and identify the staff responsible for providing advance directive notification and screening. Ensure that written advance directive notification is provided to patients and that notification and screening are documented in medical records. Require staff to document advance directives using the approved progress note title. Ensure that patient discharge orders are documented in the medical record prior to patients being discharged.

Quality Management: Ensure that peer review extensions are requested in writing from and approved by the facility Director. Strengthen medical record review processes to ensure that all required components are included, and monitor the copy and paste functions.

Environment of Care: Perform a comprehensive environment of care inspection of the chronic mental health unit, and correct identified deficiencies. Ensure that annual bloodborne pathogens training and N95 respirator fit testing are completed and that compliance is monitored.

Enteral Nutrition Safety: Ensure that enteral nutrition documentation includes all required elements.

Comments

The Veterans Integrated Service Network and Acting 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.

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 seven activities:

- COC
- EN Safety
- EOC
- Management of Workplace Violence
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through August 31, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts*,

Report No. 08-02561-75, February 24, 2009). (See Appendix B for further details.) The facility had corrected 9 of 10 findings from our previous review.

During this review, we also presented crime awareness briefings to 41 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

Reduced Inpatient Psychiatric Length of Stay

System improvements reduced the length of inpatient psychiatric stays. Staff identified that extended inpatient psychiatric stays in the last 2 years resulted from the volume of psychological testing referrals triggered by suicide risk safety assessments.

A systems redesign team reviewed and revised program procedures for safety assessments. The team implemented interventions designed to distinguish different subgroups needing safety assessments and different types of safety assessment protocols to appropriately address those needs. Prior to implementing the interventions, veterans identified as needing safety assessments had a mean length of stay of 17 days. After implementing the interventions, data from April through September 2011 indicated that the mean length of stay for those needing assessments had dropped to 12 days, representing a decrease of 30 percent. This has resulted in reduced care costs and increased access to inpatient psychiatric services.

National Leader in VA Peer Services

The facility has emerged as a national leader in the development of the VA peer service program.[1] Through the VA New England Mental Illness Research, Education, and Clinical Center's Peer Education Center, which is located at the facility, veterans from around the country have received certification training and continuing education designed to ensure that peer services are safely and successfully implemented within VA. The facility developed a full range of

[1] The program's mission is to improve the outcome of VA clinical services by providing veterans with peer support and other mutual support services.

peer services, including innovative applications of specialty services to enhance outreach to Operation Enduring Freedom/Operation Iraqi Freedom veterans, services to enhance disease self management in primary care, and services to enhance employment and college education.

Facility staff play central roles nationally in VA Central Office efforts to train peer specialists and in the development of VA Central Office guidelines for peer services. The program, which was implemented in 2005, has received two VISN innovation awards and has been a national model within VHA since 2009.

Results

Review Activities With Recommendations

COC

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

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. Additionally, we followed up on a recommendation regarding patient discharges from the previous CAP review. We identified the following areas that needed improvement.

Facility Policy. VHA requires that the facility identify the staff responsible for conducting AD notification and screening.[2] VHA also requires the facility to ensure appropriate training for staff involved in advance care planning discussions with patients. The facility's policy did not address training requirements or designate the staff responsible for providing notification and screening.

AD Notification. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[3] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of

[2] VHA Handbook 1004.02. *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[3] VHA Handbook 1004.02.

20 patients and found that none of the records contained evidence of written notification.

AD Screening. VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an AD and document the screening in the medical record.[4] Facility staff did not document this screening for 3 of the 20 patients whose medical records we reviewed.

Advance Care Planning Progress Note Titles. VHA requires that staff use a specific progress note title when filing an AD in the medical record.[5] We reviewed documentation for 20 patients and determined that the facility did not use the required progress note title in 2 of the 11 records with ADs. In addition, one of the records did not have a note indicating that an AD had been filed.

Patient Discharges. VHA requires that patients be discharged only on the order of a physician.[6] Three of the 10 medical records we reviewed did not have discharge orders in the records prior to the patients being discharged. These three patients left the facility without appropriate documentation that they had been discharged. This was a repeat finding from the previous CAP review.

Recommendations

1. We recommended that the facility AD policy be updated to include AD training requirements and to identify the staff responsible for providing AD notification and screening.

2. We recommended that processes be strengthened to ensure that written AD notification is provided to patients and that notification and screening are documented in medical records.

3. We recommended that processes be strengthened to ensure that staff document patient ADs using the approved progress note title.

4. We recommended that processes be strengthened to ensure that patient discharge orders are documented in the medical record prior to patients being discharged.

[4] VHA Handbook 1004.02.
[5] VHA Handbook 1004.02.
[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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. We identified the following areas that needed improvement.

PR. VHA policy requires facilities to complete a PR within 120 days.[7] Any extension beyond 120 days must be requested in writing from and approved by the facility Director. None of the five PRs that exceeded 120 days had the required written request and approval for extension.

Medical Record Review. VHA requires facilities to conduct medical record reviews that include specific areas of review and to monitor the copy and paste functions.[8] While medical record quality reviews had been completed, we found that they did not include all of the required components. For example, we found that the facility did not review the unsigned and co-signed discharge summaries. In addition, the facility did not monitor the copy and paste functions in the electronic medical record.

Recommendations

5. We recommended that processes be strengthened to ensure that PR extensions are requested in writing from and approved by the facility Director.

6. We recommended that medical record review processes be strengthened to ensure that all required components are included and that the copy and paste functions be monitored.

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 and whether the facility's domiciliary was in compliance with selected MH Residential Rehabilitation Treatment Program requirements.

We inspected the acute MH and chronic MH units, a community living center unit, and the domiciliary. We also inspected the UC, dental, and primary care clinics. The facility maintained a generally clean and safe environment.

[7] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[8] VHA Handbook 1907.01.

However, we identified the following conditions that needed improvement.

Cleanliness, Safety, and Maintenance on the Chronic MH Unit. The Joint Commission requires the facility to establish and maintain a safe, functional environment. During our inspection of the chronic MH unit, we observed several cleanliness issues, such as mold and rust accumulation in restroom tile grouting and visibly soiled cabinets and appliances. In addition, we observed patient safety and maintenance deficiencies, such as damaged floor tiles and baseboards that posed potential tripping hazards, water damage, and holes in walls. According to facility managers, the unit is scheduled for total renovation within the next FY; therefore, major repairs are not planned. However, the existing conditions may have an immediate effect on patient health and safety. We re-inspected the unit within 48 hours and found some improvements in general cleanliness.

Infection Control. The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule. We reviewed 12 employee training records and found that 8 employees did not have this training documented.

If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed six employee records and determined that four employees did not have the required annual fit testing.

Recommendations

7. We recommended that facility managers perform a comprehensive EOC inspection of the chronic MH unit and correct deficiencies related to patient safety, general cleanliness, and maintenance.

8. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where

EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[9] We reviewed the medical records of eight EN patients and found that two records did not include orders for or documentation of checking gastric residuals.

Recommendation

9. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Review Activities Without Recommendations

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

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 C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse managers, and reviewed initial and ongoing competency assessment and

[9] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that actions were taken when deficiencies were identified. We made no recommendations.

Comments

The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 15–20 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[10]		
Type of Organization	Long-term/psychiatric care facility	
Complexity Level	3	
VISN	1	
Community Based Outpatient Clinics	Fitchburg, MA Gloucester, MA Haverhill, MA Lynn, MA	
Veteran Population in Catchment Area	164,232	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	197	
• **Community Living Center/Nursing Home Care Unit**	174	
• **Other (Geriatric Research and Evaluation Clinical Center)**	89	
Medical School Affiliation(s)	Boston University School of Medicine Boston University School of Dentistry University of Massachusetts Medical School Harvard Medical School The New England College of Optometry Lahey Clinic	
• **Number of Residents**	45	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$163.7	$162.2
• **Medical Care Expenditures**	$82.3	$158.8
Total Medical Care Full-Time Employee Equivalents	1,238	1,231
Workload:		
• **Number of Station Level Unique Patients**	14,270	18,671
• **Inpatient Days of Care:**		
o **Acute Care**	961	2,426
o **Community Living Center/Nursing Home Care Unit**	43,063	89,233
Hospital Discharges	451	970
Total Average Daily Census (including all bed types)	356	368
Cumulative Occupancy Rate (in percent)	77.2	79.9
Outpatient Visits	100,334	215,393

[10] 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**
QM			
1. Ensure that clinical data are consistently trended over time and analyzed to identify improvement opportunities.	Management and staff completed data trending and analysis training. Quality Management Board, Medical Executive Board, and Service Line Improvement Committee minutes reflect trending and analysis of clinical data.	Y	N
2. Develop effective processes to ensure that root cause analysis action items are implemented and monitored and that the status of implementation is reported to an appropriate committee**.**	QM Board minutes reflect a reporting structure for a monthly leadership root cause analysis review that includes the implementation status of open items.	Y	N
3. Ensure that managers fully implement The Joint Commission's national patient safety goal for anticoagulation therapy.	The facility's existing anticoagulation clinic and policy have been expanded into an Anticoagulation Management Program, which fully complies with VHA policy and meets The Joint Commission's requirements. Monitors to ensure program effectiveness have been developed.	Y	N
Medication Management			
4. Ensure the documentation of PRN[11] pain medication effectiveness within the required timeframe.	Managers updated the facility's pain policy and implemented ongoing monitoring for reassessing pain interventions within the required	Y	N

[11] PRN is a Latin abbreviation (*pro re nata*) meaning as needed or as the circumstances require.

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
	timeframe. Data is reported to the Clinical Services Performance Improvement Council, the Community Living Center Pain Sub-Committee, the Nursing Service Executive Council Committee, and nurse managers.		
5. Develop a standardized medication administration procedure for patients in isolation.	Managers revised the Bar Code Medication Administration and Contingency Plan policy to incorporate procedures for patients in isolation.	Y	N
COC			
6. Ensure that nurses document patient transfer notes in accordance with facility policy.	This was a Systems Redesign Project. In addition, the Clinical Applications Coordinator developed and implemented a patient documentation transfer template. Compliance is reported to the Clinical Services Performance Improvement Council.	Y	N
7. Ensure that patient discharge orders are documented in the medical record prior to patients being discharged.	Managers sent a memorandum to physicians regarding this. Facility policies were revised, and discharge order timeliness was monitored. Data was reported to the Medical Records Review Committee.	N	Y (see page 4)

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
EOC			
8. Ensure that medication refrigerator temperatures are monitored daily and that controlled substances stored in medication refrigerators are secured.	The Associate Director for Patient/Nursing Services assigned the monitoring of the refrigerators to the night shift on each unit. In addition, outpatient nurse managers and the Chief of Pharmacy Service send a daily compliance report to the Nursing Administrative Coordinator.	Y	N
9. Ensure that suicide prevention information is available in all patient care areas.	The Suicide Prevention Coordinator conducted an assessment to determine areas that needed suicide prevention materials and collaborated with Environmental Management Service to ensure that materials are available and that suicide prevention posters are hung. Weekly rounds of all high-traffic patient areas are conducted to ensure a sufficient supply of materials.	Y	N
UC Operations			
10. Ensure that UC clinic patients receive written discharge instructions.	On December 23, 2008, specialty and acute care managers communicated to all ambulatory care staff the need for all UC clinic patients to receive written discharge instructions. In addition, an ad-hoc group modified the discharge instruction sheets. A UC template was developed and implemented, which	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
	includes a box to indicate that staff provided discharge instructions. Health Information Management staff monitor compliance and report to the Medical Records Review Committee.		

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 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

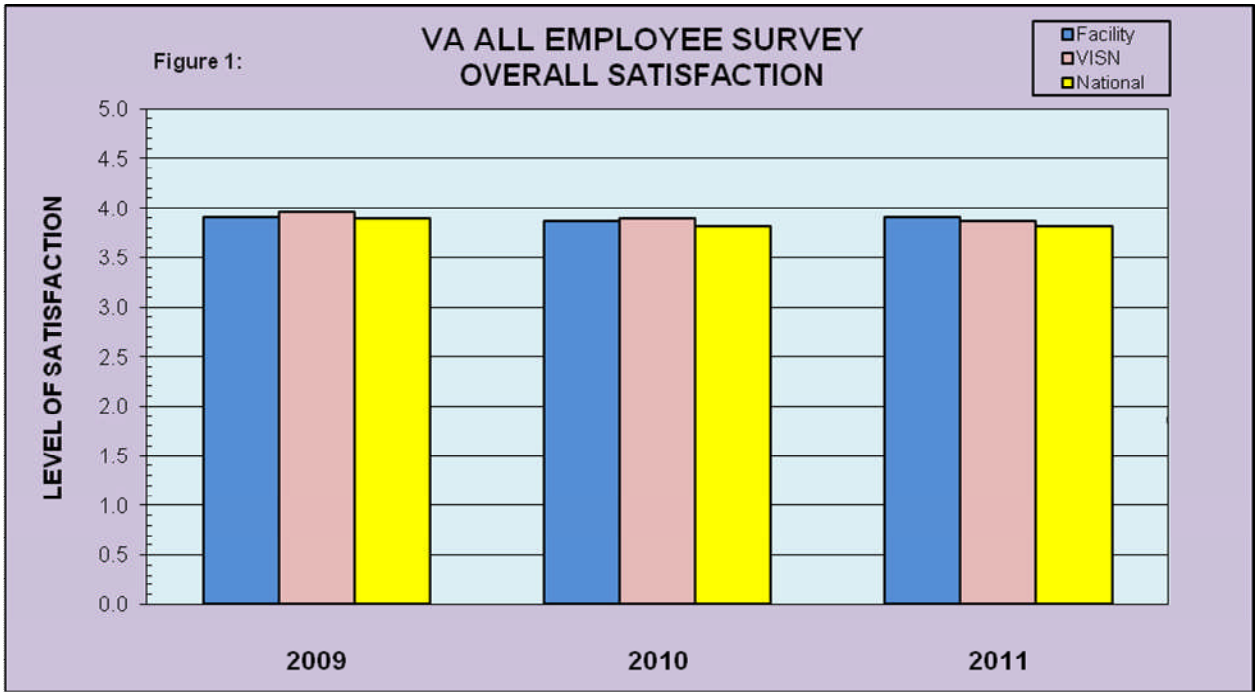
Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	61.1	63.7	*	64.5	67.2
VISN	63.5	62.7	61.6	65.2	62.3	60.6
VHA	64.1	54.8	54.4	63.9	55.9	55.3

* Not enough cases

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 8, 2011

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

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

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

Director, Management Review Service (10A4A4)

I have reviewed and concur with the findings, recommendations and action plans in the attached memorandum from the Edith Nourse Rogers Memorial Veterans Hospital.

(original signed by:)
MICHAEL MAYO-SMITH

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 24, 2011

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

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

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

1. We appreciate the opportunity to review the draft report for the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA and concur with the findings and recommendations presented in the report. Comments to the report on the following pages include our implementation plan and target dates for completion for each recommendation.

2. We would like to extend our appreciation to the Office of the Inspector General Team that conducted the review; they were very professional and provided excellent feedback to our staff. Their thorough review will provide us with an opportunity to further improve the quality of care we provide to our Veterans on a daily basis.

3. If you have any questions regarding the information provided, please contact Mr. Michael Carey, Quality Manager. Mr. Carey can be reached at (781) 687-3080.

(original signed by:)
CHRISTINE CROTEAU

Comments to Office of Inspector General's Report

The following Acting 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 facility AD policy be updated to include AD training requirements and to identify the staff responsible for providing AD notification and screening.

Concur

Target date for completion: December 31, 2011

The Advance Directive policy is being updated to include the training requirements, notification and screening process. The policy will identify staff who are responsible for the notification and screening process.

Recommendation 2. We recommended that processes be strengthened to ensure that written AD notification is provided to patients and that notification and screening are documented in medical records.

Concur

Target date for completion: April 15, 2012 (3 data points to assure sustainment)

The facility Rights and Responsibilities brochures and handouts are being updated to include the statement that the VA will not discriminate based on whether the patient has an Advance Directive. We expect to complete this by December 31, 2011. Patients will be provided this information and this notification will be documented in the medical record. This will be monitored and reported monthly to our Quality Management Board for three months (Jan thru March) to ensure sustained compliance.

Recommendation 3. We recommended that processes be strengthened to ensure that staff document patient ADs using the approved progress note title.

Concur

Target date for completion: April 15, 2012 (3 data points to assure sustainment)

Staff education has been provided by Social Work staff at various staff meetings, Grand Rounds has been presented on the entire Advance Directive process which included correct note title selection, and HIMS Manager will provide staff with educational materials on correct note title selection. This will be monitored and reported monthly to our Quality Management Board for three months (Jan thru March) to ensure sustained compliance.

Recommendation 4. We recommended that processes be strengthened to ensure that patient discharge orders are documented in the medical record prior to patients being discharged.

Concur

Target date for completion: January 31, 2012 (3 data points to assure sustainment)

Our HIMS Manager has provided guidance, with the support of the Acting Nurse Executive and Inpatient Nurse Managers, to ensure that the Clinical Support Assistants do not discharge patients in VistA until after the order is written by the discharging physician. This guidance was provided at a nursing staff meeting. HIMS Manager will conduct an ongoing monthly review of all discharge orders and report the findings to the Medical Record Review Committee monthly. The first report will be submitted at the November meeting. In addition this will be reported to our Quality Management Board for three months (November thru January) to ensure sustained compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that PR extensions are requested in writing from and approved by the facility Director.

Concur

Target date for completion: Completed

We have historically documented our reasons for Peer Review cases not being completed within the 120 day time frame on our quarterly report which was reviewed and approved by the hospital director. We have developed the extension request which will document the request for extension, in writing, and approval from the Hospital Director prospectively. This extension request will be documented in our Peer Review Committee minutes.

Recommendation 6. We recommended that medical record review processes be strengthened to ensure that all required components are included and that the copy and paste functions be monitored.

Concur

Target date for completion: January 31, 2012 (3 data points to assure sustainment)

We've modified our reporting on Unsigned and Un-Cosigned documents to break out the Unsigned and Un-cosigned discharge summaries. The first report was submitted to the Medical Record Review committee on October 17, 2011. This report will be submitted monthly.

The Copy & Paste functions will be monitored and reported monthly to the MRRC and the Compliance committee, beginning in November, 2011, for the first three months and if compliance sustained will be changed to quarterly reporting. In addition this will be

reported to our Quality Management Board for three months (November thru January) to ensure sustained compliance.

Recommendation 7. We recommended that facility managers perform a comprehensive EOC inspection of the chronic MH unit and correct deficiencies related to patient safety, general cleanliness, and maintenance.

Concur

Target date for completion: Completed

A comprehensive EOC inspection led by the Chief of Environmental Management Services was conducted which resulted in an immediate corrective action plan to address all deficiencies identified during the OIG visit. To prevent recurrence of these issues, Leadership Rounds have been initiated whereby Service Chiefs and Service Line Managers conduct environmental rounds in all clinical areas at least monthly. Areas deemed high risk are inspected weekly. Furthermore, the facility's Environment of Care Committee has been redesigned to focus more closely on understanding and mitigating patterns observed in the weekly environment of care rounds process.

Recommendation 8. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion for bloodborne pathogens training: April 15, 2012 (3 data points to assure sustainment)

Bloodborne Pathogens Training – The Exposure Control Plan has been reviewed and a process has been put in place to ensure that all appropriate managers track completion of the training for their respective employees by December 31, 2011 and then annually in the future. Compliance will be monitored monthly with routine reporting to the Infection Control Committee. Results will also be reported to the Quality Management Board for three months (January thru March, 2012) to ensure sustained compliance.

Target date for completion for N95 Respirator training: Complete

N95 Respirator – A review was conducted of all employees who are required to have N95 Respirator Fit Testing, and processes were put in place to ensure that all necessary staff receive timely Fit Testing. To improve tracking and to prevent future oversights, documentation of Fit Testing will now be entered into an Occupational Health Database in Employee Health. Fit Testing has also been scheduled to occur annually and reports will be presented at the Environment of Care Committee to ensure sustained compliance.

Recommendation 9. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Concur

Target date for completion: April 15, 2012 (3 data points to assure sustainment)

Nursing service is developing an educational presentation regarding the proper documentation requirements related to gastric feedings. All appropriate staff will be required to view this presentation by December 31, 2011. The Service Line Manager for Geriatrics and Extended Care will ensure that all providers are reminded of the importance of writing orders for EN that includes checking for gastric residuals and withholding feedings when the residual is greater than 250cc. During routine order checks and chart checks, if nursing finds any orders that do not contain these specific requirements then the order will be flagged and given to the appropriate provider for clarification. Monitoring will be done monthly to ensure that EN documentation includes all required elements and reported to our Clinical Services Performance Improvement Council. In addition this will be reported to our Quality Management Board for three months (January thru March) to ensure sustained compliance.

OIG Contact and Staff Acknowledgments

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