Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-04566-163

Combined Assessment Program Review of the James J. Peters VA Medical Center Bronx, New York

April 23, 2012

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

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CRC	colorectal cancer
EOC	environment of care
facility	James J. Peters VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
LIP	licensed independent practitioner
MH	mental health
MRI	magnetic resonance imaging
MSIT	Multidisciplinary Safety Inspection Team
OIG	Office of Inspector General
PSB	Professional Standards Board
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, NY

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 January 9, 2012.

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

- Polytrauma

The facility's reported accomplishments were development of a "Code 9" alert for suspected lung cancer and a new patient orientation program.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Initiate Focused Professional Practice Evaluations timely, and report results within the defined timeframe. Document discussion and analysis of clinical incidents that may have contributed to cardiopulmonary events. Fully implement corrective action plans, and monitor for effectiveness.

Colorectal Cancer Screening: Notify patients of positive screening, diagnostic test, and biopsy results. Ensure patients with positive screening results receive diagnostic testing. Require clinicians to develop follow-up plans or document that no follow-up is indicated.

Coordination of Care: Ensure that medications ordered at discharge match those listed on discharge instructions and that instructions define the medications to be taken after discharge.

Moderate Sedation: Ensure that designated employees complete annual moderate sedation training and that it is documented. Include all required elements in pre-sedation assessment documentation.

Medication Management: Screen patients for tetanus vaccinations upon admission and at clinic visits, and administer vaccinations when indicated.

Environment of Care: Ensure patient care areas are clean.

Follow-Up on Coordination of Care Issues: Ensure nursing transfer documentation complies with local policy.

Follow-Up on Environment of Care Issues: Establish a process to provide training on environmental hazards that represent a threat to suicidal patients to designated staff, and monitor it.

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.

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 nine activities:

- COC
- CRC Screening
- EOC
- Follow-Up on COC Issues
- Follow-Up on EOC Issues
- Medication Management
- Moderate Sedation
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through January 6, 2012, 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 James J. Peters VA Medical Center, Bronx, New York,* Report No. 09-03272-70, January 25, 2010). (See Appendix B for further details.) The facility had two repeat findings in COC and one repeat finding in EOC.

During this review, we also presented crime awareness briefings for 152 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 228 responded. Survey results were shared with facility managers.

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

Code 9 Alert for Lung Cancer

In an effort to decrease the time from suspicion of malignancy to treatment for non-small cell lung cancer, the "Code 9" alert and Lung Cancer Work-Up Panel (a physicians' order set) were developed by the Oncology Team System Redesign Work Group and Clinical Informatics staff. The Code 9 alert promptly notifies a physician of a patient's abnormal lung imaging result that might be suggestive of lung cancer. The physician can then order the Lung Cancer Work-Up Panel to ensure that diagnostic tests are not missed.

New Patient Orientation

The facility updated and streamlined the new patient orientation process to improve veterans' transition to VA services. During orientation, veterans receive information about the facility's access and health care services, and they have the option to see a primary care provider on the same day. Since February 2011, 50 new veterans have transitioned to VA services, and patient satisfaction has improved.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	LIPs' clinical privileges from other institutions were properly verified.
X	FPPE for newly hired LIPs complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a CPR review policy and process that complied with selected requirements.
X	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that FPPEs be initiated for all newly hired LIPs prior to the delivery of care and that FPPE results be reported to the PSB for consideration in making recommendations for privileges.[1] We reviewed the profiles of 10 newly hired LIPs and found that 4 FPPEs were not initiated timely (on the providers' entrance on duty dates). Further, results of seven of the nine completed FPPEs were not reported to the PSB within the defined timeframe.

Review of Resuscitation and its Outcomes. VHA requires that the CPR Committee identify opportunities to improve resuscitation processes and outcomes.[2] We found that CPR Committee meeting minutes did not reflect discussion of clinical issues that may have contributed to the occurrence of cardiopulmonary events.

Action Plans. VHA requires that when QM reviews identify specific opportunities for improvement, staff implement corrective actions and evaluate them for effectiveness.[3] We reviewed meeting minutes and found that several committees, including the Medical Records and Integrated Ethics Committees, had identified problems but had not fully implemented the corrective action plans or monitored them for effectiveness.

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs are initiated timely and that results are consistently reported to the PSB within the defined timeframe.

2. We recommended that processes be strengthened to ensure that CPR Committee meeting minutes include documentation of discussion and analysis of clinical issues that may have contributed to the occurrence of cardiopulmonary events.

3. We recommended that processes be strengthened to ensure that corrective action plans are fully implemented and monitored for effectiveness.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[3] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[4] Six patients' records did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[5] Five patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[6] One of the 14 patients who received diagnostic testing preferred a date beyond 60 days. Of the remaining 13 patients, four did not receive diagnostic testing within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the

[4] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[5] VHA Directive 2007-004.
[6] VHA Directive 2007-004.

ordering practitioner and that clinicians document notification.[7] Nine of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[8] Of the seven patients who had a biopsy, five records did not contain documented evidence of timely notification.

Recommendations

4. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

5. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

6. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

7. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

8. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[7] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
[8] VHA Directive 2007-004.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 13 HF patients' medical records and relevant facility policies, and we interviewed key employees. We also followed up on a recommendation from our previous CAP review regarding discharge medication. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Discharge Medications. The Joint Commission's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. Upon discharge from the facility, each patient receives printed copies of the physician's general discharge instructions note and the pharmacist's medication reconciliation note. The general discharge instructions note documents medications in two places and may include any combination of inpatient, outpatient, or "none found" medications. The medication reconciliation note documents inpatient and outpatient medications but instructs the patient to follow only the outpatient medications listed. All 13 patients received printouts of both notes containing multiple lists of medications that could have caused confusion. Additionally, in all 13 patient records, we found discrepancies in the medications listed on the general discharge instructions note and those listed on the medication reconciliation note. This is a repeat finding from our previous CAP review.

Recommendation

9. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions and that discharge instructions clearly define the medications to be taken after discharge.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, nine patients' medical records, and eight employee training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Competency-Based Education/Training. VHA requires that individuals administering, monitoring, and/or supervising moderate sedation have annual competency-based education and training.[9] None of the training/competency records included evidence of education/training in moderate sedation.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[10] None of the medical records included all required elements of the history and physical examination, such as a review of substance use/abuse.

Recommendations

10. We recommended that processes be strengthened to ensure that employees assisting with or providing moderate sedation complete annual training related to moderate sedation and that training is clearly documented in employee records.

[9] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[10] VHA Directive 2006-023.

11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff screened patients for pneumococcal and tetanus vaccinations.
X	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Nine (30 percent) records lacked documentation of tetanus vaccination screening.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer pneumococcal and tetanus vaccinations. Four (13 percent) records lacked documentation that indicated tetanus vaccinations had been administered.

Recommendations

12. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

13. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

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 medical/surgical, intensive care, locked MH, and spinal cord injury inpatient units; the operating room; the dental, polytrauma, and spinal cord injury clinics; the emergency department; and the CLC. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The Joint Commission requires that areas used by patients are clean. We found several areas in need of cleaning, including the emergency department, inpatient nursing stations, storage rooms, outpatient restrooms, and the pharmacy waiting room.

Recommendation

14. We recommended that processes be strengthened to ensure that patient care areas are clean.

Review Activities With Previous CAP Recommendations

Follow-Up on COC Issues

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with intra-facility transfers.

Intra-Facility Transfers. Local policy governing nursing transfer documentation requires that specific nursing transfer note templates be used. Four of the 10 transfer notes reviewed did not use the templates required by local policy.

Recommendation

15. We recommended that processes be strengthened to ensure that nursing transfer documentation complies with local policy.

Follow-Up on EOC Issues

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with MH training.

MH Training. VHA requires employees of locked inpatient MH units and members of the MSIT to complete training on environmental hazards that represent a threat to suicidal patients.[11] This training should occur initially during orientation and annually thereafter. During the previous CAP review, the facility did poorly in completing the MH environmental hazards training. In response to the recommendation from that review, the facility reported that all designated employees were trained by January 2010. However, during FY 2011, 43 (98 percent) of 44 designated employees from the acute locked inpatient MH unit and members of the MSIT did not receive annual training.

Recommendation

16. We recommended that the facility establish a process to provide training on environmental hazards that represent a threat to suicidal patients to acute locked inpatient MH unit employees and MSIT members and that the process be monitored for ongoing compliance.

[11] VHA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC),* September 22, 2011.

Review Activity Without Recommendations

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

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 20–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[12]		
Type of Organization	Tertiary 2 care medical center	
Complexity Level	1C	
VISN	3	
Community Based Outpatient Clinics	Sunnyside, NY White Plains, NY Yonkers, NY	
Veteran Population in Catchment Area[13]	NY – 950,400 NJ – 443,200 CT – 229,700	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	241	
• **CLC/Nursing Home Care Unit**	84	
• **Other**	N/A	
Medical School Affiliation(s)	Mount Sinai School of Medicine Columbia University College of Physicians and Surgeons	
• **Number of Residents**	695	
	Current FY (2012) (through December 2011)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$71	$265
• **Medical Care Expenditures**	$67	$265
Total Medical Care Full-Time Employee Equivalents	1,731.69	1,761.15
Workload:		
• **Number of Station Level Unique Patients**	15,493	24,419
• **Inpatient Days of Care:**		
o **Acute Care**	9,503	42,602
o **CLC/Nursing Home Care Unit**	6,477	24,513
Hospital Discharges	954	4,083
Total Average Daily Census (including all bed types)	174	184
Cumulative Occupancy Rate (in percent)	57.3	60.7
Outpatient Visits	89,653	328,617

[12] All data provided by facility management.
[13] As of September 3, 2010. From the National Center for Veterans Analysis and Statistics.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that managers monitor and evaluate the use of reversal agents in conjunction with moderate sedation, as required by VHA and local policies.	Monitoring of the use of reversal agents is done in conjunction with conscious sedation monitoring. The numbers have been small. Monitoring is discussed at Peri-Operative Committee meetings. There were no complications reported for FY 2011.	N
2. Ensure timely renewal of all Basic Life Support and Advanced Cardiac Life Support certifications.	CPR policy changes were made April 26, 2011, and distributed to designated staff. Staff who fail to maintain appropriate certification will be suspended from providing clinical services. A system is in place for monitoring documentation of CPR or Advanced Cardiac Life Support training. Our compliance rate for FY 2011 was greater than 92 percent.	N
3. Monitor the use of the copy and paste functions, and report trends to the appropriate committee.	Copy and paste data is reported at the Compliance, Medical Record, and Performance Improvement Committees.	N
Physician Credentialing and Privileging		
4. Ensure that professional practice evaluations are fully implemented and include supporting provider-specific profiles and that PSB meeting minutes reflect discussions regarding performance data.	Individual provider performance profiles were created for Ongoing Professional Practice Evaluations and FPPEs, which include service-specific competency criteria, targets, and data sources. PSB minutes reflect presentation by the service chief/designee for each reappointed or new hire.	N
EOC		
5. Correct the safety risk posed by wall-mounted light fixtures on the acute MH unit.	All rooms have new security light fixtures. This was completed January 15, 2010.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
6. Require staff assigned to the acute MH unit to receive the mandatory annual environmental hazard training.	Mandatory environmental training on the inpatient MH unit was initially completed in FY 2009. Since then, new staff have not completed the training. All inpatient MH staff will complete the training via the Talent Management System by the end of December 2012.	Y (see page 12)
COC		
7. Ensure nursing transfer documentation complies with local policy.	New transfer documentation was created "nursing transfer note" in FY 2009. The note is a parent-child note, which the sending and receiving nurse are required to document.	Y (see page 12)
8. Ensure that discharge summaries and instructions include all VHA required elements and that the information in discharge documentation is consistent.	Discharge summaries were reviewed, and all missing elements were added in FY 2009.	Y (see page 7)
MRI Safety		
9. Require that MRI technologists screen all patients prior to MRI procedures and that the screening is documented in the patient's medical record.	MRI technicians document in the comment section of the request in the radiology package. Compliance is monitored monthly. Compliance for FY 2010 and FY 2011 was 100 percent.	N

VHA Satisfaction Surveys

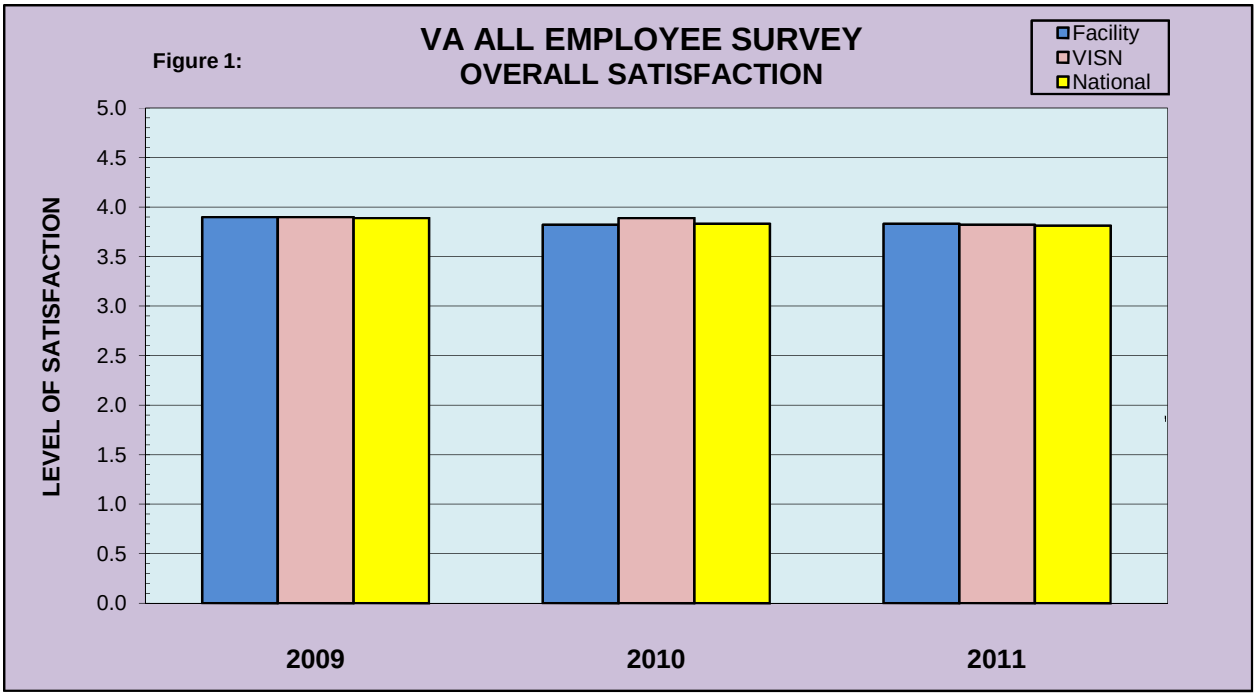
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	65.7	66.7	59.4	62.2	49.0	58.0
VISN	61.8	60.4	60.0	59.4	57.2	56.7
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[14] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[15]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	9.2	12.1	**	33.7	21.1
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[14] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[15] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 11, 2012

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

Subject: **CAP Review of the James J. Peters VA Medical Center, Bronx, NY**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. I have reviewed the recommendations of the Combined Assessment Program Draft Report of the James J Peters VA Medical Center conducted by the OIG team during the week of January 9–13, 2012.

2. I concur with the sixteen recommended improvements in the report.

3. Should you have any questions, please contact Pamela Wright, VISN QMO, at 718-741-4143.

Michael A. Sabo, FACHE
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 1, 2012

From: Director, James J. Peters VA Medical Center (526/00)

Subject: **CAP Review of the James J. Peters VA Medical Center, Bronx, NY**

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

1. We have reviewed the recommendations of the Combined Assessment Program Draft Report of the James J Peters VA Medical Center conducted by the OIG team during the week of January 9–13, 2012.

2. We concur with the sixteen recommended improvements sought forth in the report. Recommendation #14 was completed during the survey and the additional sustainability plan was also discussed.

3. Should you have any questions, please contact our Quality Manager at Ext. 5264.

MARYANN MUSUMECI
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs are initiated timely and that results are consistently reported to the PSB within the defined timeframe.

Concur

Target date for completion: July 6, 2012

During the survey it was identified the FPPE's were completed in the Credentialing and privileging file. An issue was identified in a few instances where the completed document dates were not synchronized with the entrance on duty date of the physician. In order to address the finding, the PSB during their monthly meeting will have Human Resources verify provider's entrance on duty date in order to ensure timeliness in the submission. In addition, a monthly electronic tracking report by Credentialing office will be generated to remind Service Chiefs of timely submission of FPPE's to the PSB committee.

Recommendation 2. We recommended that processes be strengthened to ensure that CPR Committee meeting minutes include documentation of discussion and analysis of clinical issues that may have contributed to the occurrence of cardiopulmonary events.

Concur

Target date for completion: August 3, 2012

Facility CPR committee reviews all cardiopulmonary episodes within the Medical Center and its outcomes according to VHA Directive 2008-063. The committee has done an excellent job in the analysis of all events including aggregate reviews, for the purpose of identifying problems, analyzing trends, and benchmarking for opportunities for improvement, and when problems are determined, to recommend specific actions and ensure those actions are implemented.

Reviews of episodes of care of individual cases needed to be further explained in the committee minutes. In order to strengthen the committee minutes, the CPR committee will include discussions and analysis of individual clinical incidents that may have contributed to the occurrence of cardiopulmonary events and document the resolution in their meeting minutes. Reports will be discussed at the Performance Improvement committee on a quarterly basis.

Recommendation 3. We recommended that processes be strengthened to ensure that corrective action plans are fully implemented and monitored for effectiveness.

Concur

Target date for completion: August 3, 2012

During the survey the Medical Records Committee minutes did not reflect action plans for a particular area of improvement. The ethics committee's minutes followed up all actions but missed a Preventive Ethics follow up report on a project in 2011. The Ethics committee provided the report during the survey and reported the information in the January meeting. The Medical Records committee particular action plan will be reviewed and followed to completion.

The process of addressing action plans will be identified under the follow up heading to closure. Closure of the item will also be reflected in the meeting minutes. Reports will be discussed at the Performance Improvement committee on a quarterly basis.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians' document notification.

Concur

Target date for completion: August 3, 2012

Patients are being notified of positive CRC screening test results by phone or by mail, within the required time frame and clinicians should document the notification in CPRS. During the survey, 6 out of 20 cases did not have documentation of the notification.

In order to avoid issues related to lack of documentation, the GI Practice will monitor the patient notification of positive fecal occult blood test (FOBT) results and notification of possible follow up tests by providers as part of a quality improvement process. Ordering providers have been notified of this process and documentation expectations. Reports will be forwarded to the Performance Improvement committee on a quarterly basis.

Recommendation 5. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: August 10, 2012

Patients are informed of the outcome for CRC screenings, either by phone or mail. This process is completed within 14 days of the test notification results. During the survey it

was identified that in 5 of 20 cases the information was not documented in the patient record.

In order to avoid issues related to lack of documentation the ordering providers have been informed, that follow up plans are to be documented in the patient record when CRC screening is done.

The GI Practice will monitor the consultative process of positive FOBT results by providers who have ordered the test as part of a Quality Improvement process. The report will be presented at the Performance Improvement committee on a quarterly basis.

Recommendation 6. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: June 1, 2012

Patients with positive CRC screening test results receive diagnostic testing within the required timeframe of sixty days. During the survey, 4 out of 13 cases were found not to have received diagnostic testing within the 60 days timeframe. It was not documented in the patient's record whether the scheduling past the 60 days was at the request of the veteran.

In order to avoid issues related to scheduling of the procedures the ordering providers have been reminded that patients with positive CRC screening need follow up diagnostic testing within 60 days of the results. Patients who prefer diagnostic testing after the 60 days, the decision must be reflected in the patients' record or scheduling software.

In order to ensure compliance with this process the GI Practice will monitor the scheduling of colonoscopies for patients referred to GI clinic after a positive FOBT. The report will be presented at the Performance Improvement committee on a quarterly basis.

Recommendation 7. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: August 10, 2012

Patients are notified of diagnostic test results within 14 days of the procedure. These occur right after the patient has completed the diagnostic test, before discharge. It was

identified during the survey that documentation of the discussion was not present in 9 out of 14 cases.

In order to comply with the notification of test results within the fourteen day required time frame, the physician will give the patient a written summary of his/her findings, recommended surveillance instructions, and recommended clinic follow-up, if needed after his/her procedure. This process will be documented in the GI nursing note upon discharge. The GI Practice will monitor this activity as part of their Quality Improvement process. The report will be presented at the Performance Improvement committee on a quarterly basis.

Recommendation 8. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: August 10, 2012

Patients are notified by phone of biopsy results within 14 days of the procedure. It was identified during the survey that documentation of the discussion was not present in five out seven cases. All five patients were contacted of their biopsy results and documented in CPRS.

In order to strengthened this process the GI Practice has developed a system in which GI pathology results are being forwarded to the endoscopy physician. A GI Pathology Patient Notification Template has also been developed in the electronic medical record to facilitate patient communication. The GI Practice will monitor this activity as part of their quality improvement process. The report will be presented at the Performance Improvement committee on a quarterly basis.

Recommendation 9. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions and that discharge instructions clearly define the medications to be taken after discharge.

Concur

Target date for completion: September 7, 2012

The medication reconciliation process has been >90% compliant. A finding was identified that in some cases the reconciliation list did not match.

A careful review of the discharge process and medication reconciliation was conducted and found that the system was pulling a different list into the discharge instructions. In order to eliminate any systems issues changes to the document are as follows. 1. The Instructions written in a language that patient and/or the caregiver understands, 2. A statement will appear in the discharge instructions that refer the patient to the

medication reconciliation list given to the patient by the pharmacist who conducts the medication teaching. The QM department will monitor the process on a quarterly basis and reported to the Performance Improvement Committee.

Recommendation 10. We recommended that processes be strengthened to ensure that employees assisting with or providing moderate sedation complete annual training related to moderate sedation and that training is clearly documented in employee records.

Concur

Target date for completion: June 1, 2012

All employees assisting or providing moderate sedation have completed their training related to moderate sedation and is documented in TMS. As of April 4, 2012, 99% of employees in these areas have completed the training. One employee is out on extended leave at the current time. In order to ensure compliance with training, nursing will review compliance with training every 6 months.

Recommendation 11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: June 1, 2012

It was found during the review that three elements were missing out of the template note for pre sedation assessment. The current template note for pre-sedation assessment was modified to reflect the additional items. The additions were completed on 2/28/12. The following options have been added to the "physician pre-sedation/analgesia note:

1. Smoking
2. Alcohol
3. Drugs

Documentation will be monitored on a monthly basis and reported to the Operative and other procedures committee on a quarterly basis for the next 6 months.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: June 1, 2012

In January of 2011, the Advisory Committee on Immunization Practices (ACIP) called for vaccination with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis

(Tdap) for adolescents and adults to improve immunity against pertussis, Tdap coverage is 56% among adolescents and <6% among adults. In October 2010, ACIP recommended expanded use of Tdap vaccine.

Prior to the OIG visit the infection control group looked at the Tdap vaccine usage and concentrated on employee vaccinations first. Prior to the OIG survey, a discussion was made to acquire a reminder that would assist clinicians in determining who needed the vaccine in order to expand to the patient population.

In order to establish a tracking process, a recommended clinical reminder has been developed for the Td and Tdap vaccine screening and administration. The preferred vaccine is the TDAP. A standing order protocol has been developed. Educational in-services have been provided and will be on- going regarding the Td/Tdap vaccine and reminder. The clinical reminder will be activated in PACT teams followed by the specialty clinics. The clinical reminder will be effective for the PACT teams mid-April. Pharmacy will monitor vaccine usage and order accordingly. Td/Tdap vaccine screening and administration will be monitored with quarterly data collection. Further, education of providers will be based on Td/Tdap screening and usage results. Reports will be made to the Medical Executive Committee on a quarterly basis.

Recommendation 13. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Concur

Target date for completion: June 1, 2012

Same as above.

Recommendation 14. We recommended that processes be strengthened to ensure that patient care areas are clean.

Concur

Target date for completion: August 10, 2012

All areas mentioned in the OIG report were cleaned during the survey.

In order to sustain the cleanliness, the EOC will conduct inspections on a weekly basis. The housekeeping supervisor will follow up with any corrective actions identified during the inspections then the area will be inspected again by the EOC Specialist, all within the same week. Reports will be provided to the Associate Medical Center Director and the EOC on a monthly basis.

Recommendation 15. We recommended that processes be strengthened to ensure that nursing transfer documentation complies with local policy.

Concur

Target date for completion: August 10, 2012

The current process of transferring documentation has been monitored for compliance purposes. Based on the recent results the Nursing program re-evaluated the process of transfer documentation. SOP 118-02, Hand off communication, has been modified to include documentation expectations from all inpatient units and procedure areas. Units will monitor compliance with documentation on a monthly basis and data will be submitted to the Patient Care Center Directors. Reports with corrective actions as identified will be submitted to the Nursing Inter-practice council on a quarterly basis.

Recommendation 16. We recommended that the facility establish a process to provide training on environmental hazards that represent a threat to suicidal patients to acute locked inpatient MH unit employees and MSIT members and that the process be monitored for ongoing compliance.

Concur

Target date for completion: July 1, 2012

In 2009, the Environment hazards training was a new requirement for the inpatient locked unit. At the time an educational program was provided to all staff. When looking at the most recent statistics before the OIG visit, it was found that the module in TMS created for this purpose was not loaded and assigned to the staff. Prior to the OIG visit in January efforts were made to have everyone trained.

The training on environmental hazards that represent a threat to suicidal patients to acute locked inpatient MH units has been loaded and assigned to all appropriate personnel in MH inpatient unit employees and MSIT members in TMS. As of March 23rd, 100% of employees has completed the training.

Through the TMS system, this training will be monitored for compliance. A review will be conducted every 6 months by the MH Nurse Manager to ensure that all staff, including new hires, are trained.

OIG Contact and Staff Acknowledgments

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