Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01289-227

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

August 5, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	James J. Peters VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of May 5, 2014.

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

- Coordination of Care

The facility's reported accomplishments were its response to Superstorm Sandy and physician awards.

Recommendations: We made recommendations in the following six activities:

Quality Management: Complete actions from peer reviews, and report them to the Peer Review Committee. Report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Ensure Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Require that electronic health record data is analyzed and reported at least quarterly in Electronic Health Record Committee meeting minutes. Implement a quality control policy for scanning. Ensure that the Blood Usage Review Committee includes a member from Medicine Service, that the member from Surgery Service consistently attends meetings, and that the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria. Consistently follow actions taken when data analyses indicate problems or opportunities for improvement to resolution in the Cardiopulmonary Resuscitation, Operative and Other Procedures, Peer Review, and Environment of Care Committees.

Environment of Care: Clean glucometers between patients, replace damaged glucometer cases, and routinely clean optical examination equipment.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

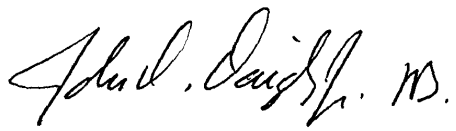
Acute Ischemic Stroke Care: Ensure clinicians complete and document National Institutes of Health stroke scales for each stroke patient and screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge.

Community Living Center Resident Independence and Dignity: Document the reasons for discontinuing or not providing restorative nursing services when those services are care planned.

Magnetic Resonance Imaging Safety: Establish written procedures for handling emergencies in magnetic resonance imaging (MRI). Conduct cardiac and contrast reaction emergency drills in MRI. Ensure radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan. Designate additional Level 2 MRI personnel, and require that all designated Level 1 ancillary staff and Level 2 MRI personnel receive annual level-specific MRI safety training. Ensure appropriate screening is in place to restrict access to MRI Zones III and IV.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–29, for the full text of the Directors' comments.) 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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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

The review covered facility operations for FY 2013 and FY 2014 through February 24, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York,* Report No. 11-04566-163, April 23, 2012). We made repeat recommendations in QM.

During this review, we presented crime awareness briefings for 269 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 191 responded. We shared summarized results 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

Superstorm Sandy

On October 29, 2012, the Tri-State Area was impacted by Superstorm Sandy. In the days prior, the facility actively prepared for the anticipated hazards of this severe weather event with emphasis on notifying staff and patients and securing the physical plant. When the Manhattan campus of the VA New York Harbor Healthcare System was forced to close, the facility assumed the care of approximately 1,000 patients. In addition, the Emergency Management Team collaborated with Nutrition and Hospitality Service to arrange shelter-in-place for more than 120 staff essential to maintain operations during the storm. To address the severe storm-related employee transportation challenges, the facility created a ride-share website; increased the number of shuttles and provided fuel on an as needed emergency basis; and communicated minute-by-minute updates regarding transportation, fuel availability, and safety issues.

Physician Awards

Drs. William Bauman and Ann Spungen were declared finalists for the 2014 Service to America Awards for their leadership of multidisciplinary work in spinal cord injury that has led to the development of innovative approaches and effective interventions to improve the health and quality of life for paralyzed persons.

Dr. Mary Sano, Director of Research and Director of the Alzheimer Research Disease Center, was awarded the 2014 Federal Executive Board's Employee of the Year Award (Scientific Achievement). Dr. Sano provided scientific leadership and research ingenuity in establishing the efficacy of vitamin E in the treatment of Alzheimer's disease. Dr. Sano joins previous facility "Distinguished Scientist" award winners Dr. Rachel Yehuda (2008), Dr. John Eng (2009), and Dr. Gregory Elder (2011).

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • None of the seven actions expected to be completed were reported to the PRC.
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Thirteen profiles reviewed: • The results of six Focused Professional Practice Evaluations were not reported to the MEC.
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to the codes that may have contributed to the occurrence of the codes. This was a repeat finding from the previous CAP review.
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	• Twelve months of data were collected but were not analyzed or reported in EHR Committee meeting minutes.
X	The policy for scanning non-VA care documents met selected requirements.	• The facility did not have a scanning policy.

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Twelve months of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Surgery Service attended only one meeting, and there was no clinical representative from Medicine Service. • The review process did not include the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently followed to resolution for the Cardiopulmonary Resuscitation Committee, the Operative and Other Procedures Committee, and the PRC. This was a repeat finding from the previous CAP review.
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are completed and reported to the Peer Review Committee.

2. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

3. We recommended that processes be strengthened to ensure that Cardiopulmonary Resuscitation Review Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

4. We recommended that processes be strengthened to ensure that electronic health record data is analyzed and reported at least quarterly in Electronic Health Record Committee meeting minutes.

5. We recommended that the facility implement a quality control policy for scanning.

6. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee includes a member from Medicine Service, that the member from Surgery Service consistently attends meetings, and that the blood/transfusions usage review process includes

the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

7. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in the Cardiopulmonary Resuscitation, Operative and Other Procedures, Peer Review, and Environment of Care Committees.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the intensive care, medical/surgical, and acute MH units and the CLC. We also inspected the emergency department, the SDS/PACU areas, and the dental and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 35 employee training records (20 SDS, 10 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were tracked to closure. (See recommendation 7 in QM.)
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• In two of six patient care areas, we found dirty glucometers. • In three of six patient care areas, we found glucometer cases that were held together with medical tape and were dirty.
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
X	Infection prevention requirements in the eye clinic were met.	• In all five exam rooms, we found a thick layer of dust on all of the optical equipment.
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

8. We recommended that processes be strengthened to ensure that glucometers are cleaned between patients, damaged glucometer cases are replaced, and optical examination equipment is cleaned routinely and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For five of the eight patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

9. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 10 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether VHA facilities complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 30 patients who experienced stroke symptoms, and 8 staff training records (5 emergency department and 3 intensive care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, a critical care unit, and three acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twelve EHRs (40 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Twelve of the 29 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 27 applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff involved in assessing and treating stroke patients.	
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

12. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 15 EHRs of residents (6 residents receiving restorative nursing services and 9 residents not receiving restorative nursing services but candidates for services). We also observed two meal periods, reviewed four employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• Of the nine EHRs where restorative nursing services were care planned but were not provided or were discontinued, two did not reflect the reasons.
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

13. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

MRI Safety

The purpose of this review was to determine whether VHA facilities ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 33 employees (30 randomly selected Level 1 ancillary staff and 3 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• Facility policy did not address procedures for handling emergencies in the MRI area, such as a cardiac arrest, a contrast reaction, or a quench. • Cardiac and contrast reaction emergency drills were not conducted in the MRI area.
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Four of the nine applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Level 1 ancillary staff did not receive level-specific annual MRI safety training. • Although there were other staff who required Level 2 access, the facility designated only three MRI employees as Level 2 personnel. • The three designated Level 2 MRI personnel did not receive level-specific annual MRI safety training.
X	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	• Individuals other than screened patients and level 2 MRI staff were not screened prior to entry into Zones III and IV.
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	

NM	Areas Reviewed (continued)	Findings
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that the facility establish written procedures for handling emergencies in magnetic resonance imaging and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that cardiac and contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

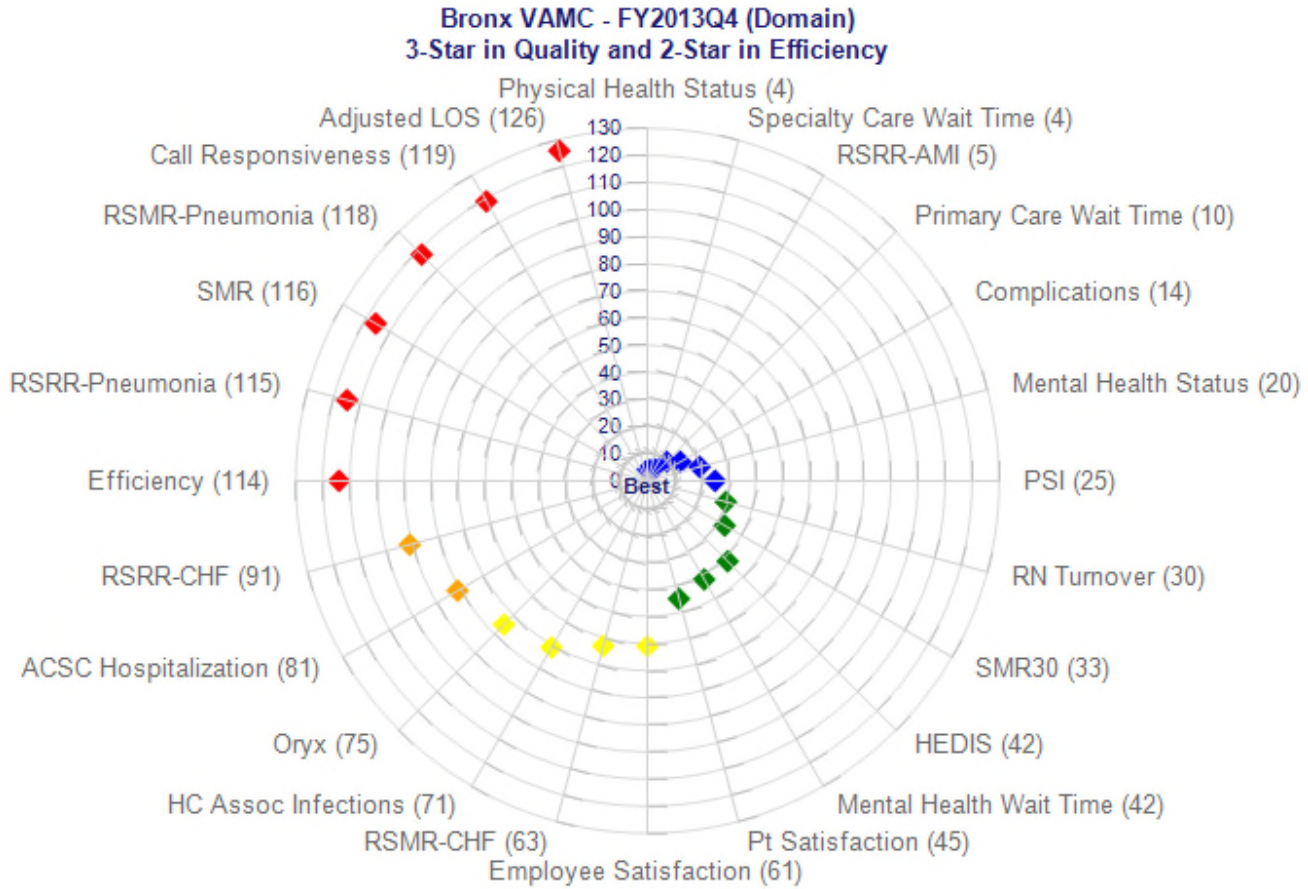
17. We recommended that additional Level 2 magnetic resonance imaging personnel be designated, that processes be strengthened to ensure that all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training, and that compliance with training be monitored.

18. We recommended that appropriate screening be in place to restrict access to magnetic resonance imaging Zones III and IV.

Facility Profile (Bronx/526) FY 2014 through May 2014[1]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$265.5
Number of:	
• **Unique Patients**	21,844
• **Outpatient Visits**	224,204
• **Unique Employees**[2]	1,472
Type and Number of Operating Beds (April 2014):	
• **Hospital**	245
• **CLC**	80
• **MH**	0
Average Daily Census (April 2014):	
• **Hospital**	98
• **CLC**	63
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	White Plains/526GA Yonkers/526GB South Bronx/526GC Queens/526GD
VISN Number	3

[1] All data is for FY 2014 through May 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

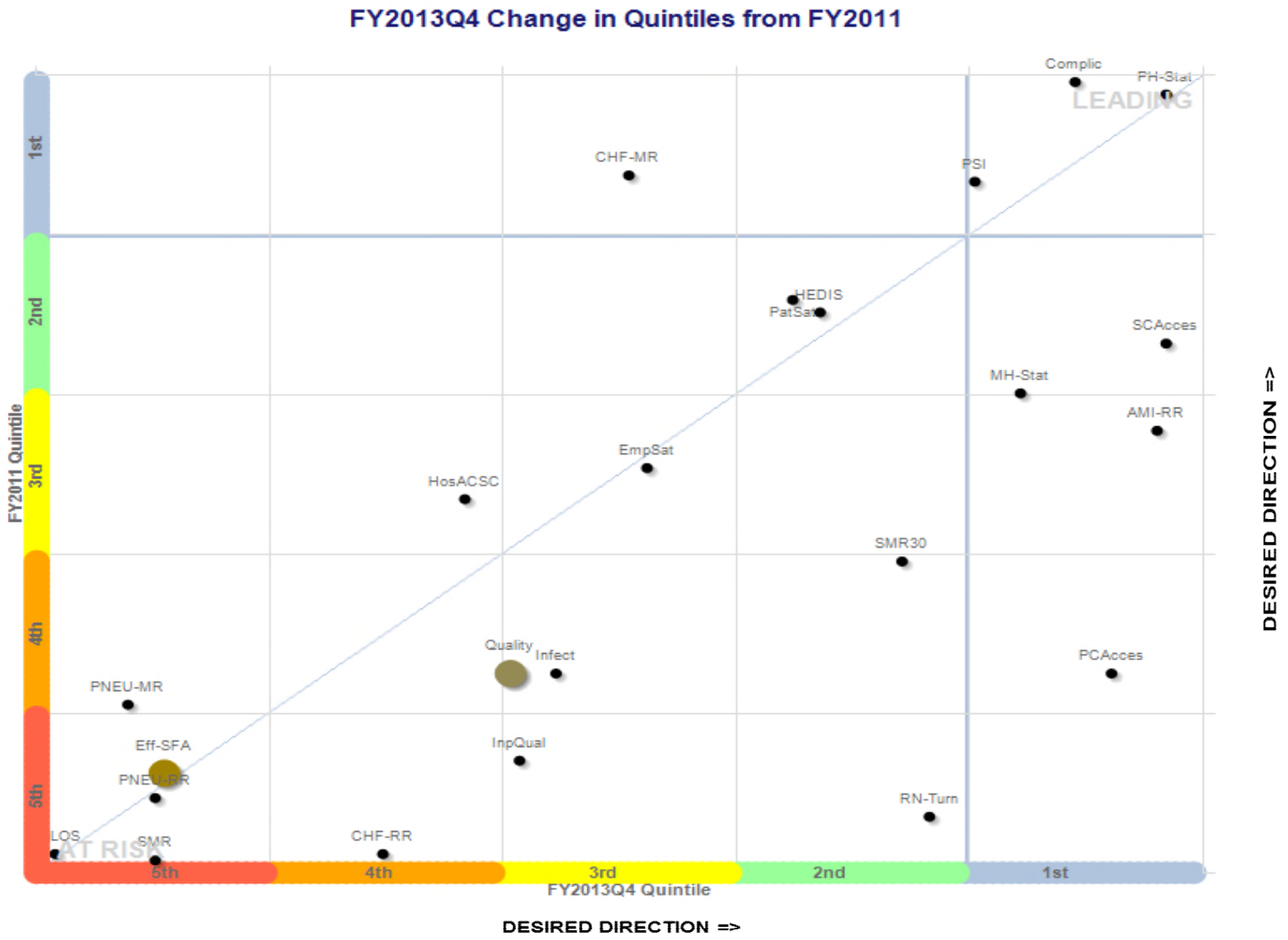
Strategic Analytics for Improvement and Learning (SAIL)[3]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2014

From: Director, VA New York/New Jersey 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 10AR MRS OIG CAP CBOC)

1. I have reviewed the recommendations of the Combined Assessment Program Review draft report of the James J. Peters VA Medical Center conducted by the OIG team during the week of May 5, 2014.

2. I concur with the eighteen recommendations for improvements set forth 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: June 25, 2014

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 New York/New Jersey 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 May 5, 2014

2. We concur with the eighteen recommendations for improvements set forth in the report.

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

Erik Langhoff, MD
Medical Center Director

Comments to OIG's Report

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that actions from peer reviews are completed and reported to the Peer Review Committee.

Concur

Target date for completion: 11/1/14

Facility response: Systems improvement recommendations from Peer Review Committee and service actions for final level 2 and 3 Protected Peer Reviews will be tracked using excel database. The responses from the service chiefs and practice chiefs related to provider recommendations for level 2 and 3 will be tracked and documented in the peer review minute template. Items will remain open until completion. The excel data base will be audited against Peer Review Committee minutes over 6 months to ensure 90% of the actions and recommendations from Peer Review discussions are being tracked and closed appropriately. This will be monitored for a period of three months. Compliance: 90%

Recommendation 2. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluation results for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur

Target date for completion: 09/30/14

Facility response: Due to changes in leadership for the credentialing and privileging process a new plan has been developed to be able to track FPPE's on a timely fashion. The plan starts when an appointment, or privilege, is approved at the PSB, the FPPE evaluation form will be generated and given to the Service Chief for completion. The letter to the Service Chief and a copy of the FPPE will be included in the Provider's folder.

A note will be made in the minutes of the PSB that the FPPE has begun, with the due date. This notice will not be removed until all requirements of the FPPE are completed. A follow-up memo will be sent to the Service Chief one month prior to the expected date of completion. A copy of all follow-ups will be included in the Provider's folder. Once the FPPE is returned to the PSB it will be signed by the Chief of Staff and recorded as completed. All completed Focus Reviews will be reported in the next PSB meeting. Close monitoring will be conducted monthly for a three month period to ensure compliance and quarterly thereafter. Compliance: 90%

Recommendation 3. We recommended that processes be strengthened to ensure that Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: 9/30/14

Facility response: Clinical data of occurring codes are reviewed at each quarterly CPR committee meeting. Committee meeting minutes have not always reflected this due to technological inexperience and decrease in supervision. We are in the process of training an individual who is more experienced to assist with completing the minutes. The committee chairperson will take more of a supervisory role. Thus minutes will reflect monitoring of clinical issues during codes effective immediately (next meeting July 2014). Monitoring for sustained improvement should occur for three months. Compliance: 90%

Recommendation 4. We recommended that processes be strengthened to ensure that electronic health record data is analyzed and reported at least quarterly in Electronic Health Record Committee meeting minutes.

Concur

Target date for completion: 12/31/14

Facility response: The facility leaders met with the Chair of the Medical Records Committee to discuss actions needed to ensure the committee follows the required guidelines. A new agenda and minutes including reporting structure was developed to follow actions and discussions of the committee quarterly meetings. A new co-chair was identified, as well as a program assistance to assist in the follow up actions and minutes taking of the committee. Reports and committee minutes will be saved in the Facility Share drive and paper records will be kept for a year to ensure no information is lost. The next committee meeting will take place in August 2014. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 5. We recommended that the facility implement a quality control policy for scanning.

Concur

Target date for completion: 12/31/14

Facility response: Facility is in the process of instituting a scanning unit where staff will be specifically trained to scan all documents being incorporated into CPRS. This process is currently done in a decentralized fashion. The protocol will be to scan, verify and file. All scanned documents will then be verified accurate by a scanning quality control staff member whose sole purpose will be to assure the legibility of all scanned documents. The Clinical Applications coordinator will monitor 10% of scanned records

on a monthly basis and report to the Medical Records committee on a quarterly basis. Compliance: 90%

Recommendation 6. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee includes a member from Medicine Service, that the member from Surgery Service consistently attends meetings, and that the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: 9/30/14

Facility response: A meeting was conducted with the Chief of Staff and the Associate Director to address the lack of attendance of the surgical representatives at the blood usage committee. Three new members from Medicine Service were added to the committee membership. In order to ensure providers attend committee meetings, attendance will be monitored and those not attending will be reported to the Chief of staff on a quarterly basis. This item will be added to the providers pay for performance for FY 2015.

Proficiency testing and results of peer review are now standing agenda items. Three providers agreed to do all clinical peer reviews when the transfusions did not meet criteria. As discussed in the OIG interview, the blood bank technologist and the supervisor medical technologist will continue to review 90% of all transfusions. Monitoring for sustained improvement should occur for 3 consecutive months. Compliance: 90%

Recommendation 7. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in the Cardiopulmonary Resuscitation, Operative and Other Procedures, Peer Review, and Environment of Care Committees.

Concur

Target date for completion: 12/30/14

Facility response: Met with chairs of individual committees and provided a standardized minute document and tracking grid to ensure consistency of minutes taking and follow up actions. The Quality department will review the committee minutes to ensure the process is followed consistently. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 8. We recommended that processes be strengthened to ensure that glucometers are cleaned between patients, damaged glucometer cases are replaced, and optical examination equipment is cleaned routinely and that compliance be monitored.

Concur

Target date for completion: 09/30/14

Facility response: All glucometers that were found to be broken or in state of disrepair were replaced by the Laboratory medical technologist for Point of care. The Blood Glucose Procedure Book is currently on every unit. The procedure book states that the glucometers and their cases are to be cleaned after each patient use by Hydrogen Peroxide Wipes. The procedure for cleaning after each patient use was reinforced with the staff. The SOP 11-9 Ancillary Blood Glucose Monitoring (BGM) is currently been updated to include cleaning of glucometers and cases after each patient use. In services will be provided to the staff to ensure processes are followed.

Optical examination equipment is cleaned by the Ophthalmology Technicians on a weekly basis. Compliance will be monitored through environmental rounds conducted by the clinic manager on a weekly basis. A tracking tool will be developed to track compliance. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The clinicians conducting medication education will document appropriate educational strategy for those individuals with identified learning barriers, within the discharge medication reconciliation process. The clinical managers will monitor compliance by reviewing 30 charts per month on the med surg units. This will be reported to the PIC committee on a quarterly basis. Compliance: 90%

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The current data shows that the Bronx is at 64% compliance with documentation of NIH stroke scale as of 2nd Qtr 2014. ICU, ER and Neurology service will receive one to one education on the process of documenting NIH stroke scales, using the stroke note which contains all elements needed for the compliance in this process. The Chief of neurology will review all (100%) stroke notes on a monthly basis to ensure compliance. Data will be reported quarterly to the PIC committee. Compliance: 90%

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: 12/31/14

Facility response: The current data shows that the Bronx is at 59% compliance with documentation of swallowing evaluations as of 2nd Qtr 2014. ICU, ER and Neurology service will receive one to one education on the process of documenting swallowing evaluation, using the stroke note which contains all elements needed for the compliance in this process. The Chief of Neurology will review all (100%) stroke notes on a monthly basis to ensure compliance. Monitoring for sustained improvement should occur for three consecutive months. Expected Compliance: 90%

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Nursing discharge template will be adjusted to add documentation on stroke education. Educational material will be added to the tools section in CPRS so staff can print and provide to patients on discharge. The Unit Managers will monitor all (100%) patients admitted with a stroke diagnosis nursing documentation to ensure compliance. Monitoring for sustained improvement should occur for three consecutive months. Expected Compliance: 90%

Recommendation 13. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Residents identified to be on the Restorative Nursing Program are identified on admission, and then discussed during the interdisciplinary team meeting

and care plan meeting. The resident and/or NOK is involved as appropriate. If the resident is deemed not a candidate or refuses, the reason is documented in CPRS. In order to ensure compliance 10 charts per month will be monitored by the RN overseeing the Restorative Nursing program. Monitoring for sustained improvement should occur for three consecutive months. Expected compliance: 90%.

Recommendation 14. We recommended that the facility establish written procedures for handling emergencies in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 09/30/14

Facility response: Facility has a written emergency procedure and policy for fire in the MRI suite and had a drill conducted in June 2013. Through the MRI Safety Committee procedures and policies to address cardiac arrest, contrast reaction and a quench in MRI will be developed. The MRI Committee meets quarterly and is due to meet in July 2014. Yearly drills will be scheduled, performed and compliance monitored through the safety committee and documented in the committee minutes. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 15. We recommended that processes be strengthened to ensure that cardiac and contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 9/30/14

Facility response: Through the MRI Safety Committee procedures and policies to address cardiac arrest, contrast reaction and a quench in MRI will be developed. The MRI Committee meets quarterly and is due to meet in July 2014. Yearly drills will be scheduled, performed and compliance monitored through the safety committee and documented in the committee minutes. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 16. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 09/30/14

Facility response**:** Radiologist and technologist will document on the requisition form how the potential imaging contraindication was resolved and have it signed by the

responsible technologist, or radiologist. The order will be scanned into the EHR. The MRI Safety Committee will conduct random chart reviews (10 per month) to ensure compliance. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 90%

Recommendation 17. We recommended that additional Level 2 magnetic resonance imaging personnel be designated, that processes be strengthened to ensure that all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training, and that compliance with training be monitored.

Concur

Target date for completion: 09/30/14

Facility response: Level 1 and level 2 staff have been identified and assigned level-specific annual MRI safety training. Level 2 staff will include biomedical engineering personnel, designated housekeeping personnel, MRI radiologists, MRI technologists, and Radiology Nurse. Training compliance will be monitored quarterly through MRI Safety Committee. Compliance: 90%

For communication purposes, a sign will be posted at the entrance of the level 2 MRI Suite that indicates that only personnel trained and assigned to this area will be allowed in this particular section. The floor will also be marked with a red color to identify area limits.

Recommendation 18. We recommended that appropriate screening be in place to restrict access to magnetic resonance imaging Zones III and IV.

Concur

Target date for completion: 09/30/14

Facility response: The Chief of Radiology recommended to the radiology group, that only level 1 and 2 trained personnel and screened patients will be allowed to enter zone III or IV. Screening of personnel that includes; Nursing, Housekeepers, MRI manufacturer's technician, will be conducted by the MRI technologist every time there is a request to enter Zone III or IV. The technician will then, keep completed forms in a secure location. If a code is called in the MRI suite (zone III or IV) the patient will be moved out to zone I or II for the team to intervene. An SOP will be developed to address extreme circumstances where patient is unable to move out of the room.

In order to monitor compliance the MRI technologist will report to the Radiation Safety Committee the number of instances non patient personnel had to enter Zone III or IV and provide compliance with screening documents on a monthly basis. This will be discussed at the next Radiation Safety committee for concurrence. Monitoring for sustained improvement should occur for three consecutive months. Compliance: 100%

OIG Contact and Staff Acknowledgments

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.