Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04693-79

Combined Assessment Program Review of the Corporal Michael J. Crescenz VA Medical Center Philadelphia, Pennsylvania

January 14, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Corporal Michael J. Crescenz VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 October 26, 2015.

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

- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishment was leading a citywide collaborative to reduce veteran homelessness.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months. Consistently implement individual improvement actions recommended by the Peer Review Committee.

Environment of Care: Ensure patient care areas are clean. Repair damaged furniture, or remove it from service, and replace stained ceiling tiles. Comply with local policy for labeling multi-dose vials with expiration dates after initial use. Require all dental clinic employees to complete bloodborne pathogens training annually and hazard communication training on chemical classification, labeling, and safety data sheets.

Medication Management: Store compounded hazardous medications separately from other inventory. Document weekly testing of the emergency eyewash station in the chemotherapy pharmacy.

Coordination of Care: Revise the patient discharge policy to include scheduling discharges early in the day. Revise the temporary bed locations policy to include upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision. Require clinicians to validate patients' and/or caregivers' understanding of the discharge instructions provided.

Suicide Prevention Program: Ensure that new employees complete suicide prevention training and that new clinical employees complete suicide risk management training within the required timeframe. Complete required reports regarding patients who attempt or complete suicide. Ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan.

Mental Health Residential Rehabilitation Treatment Program: Have a Class K fire extinguisher available for the domiciliary teaching kitchen. Require domiciliary residents

to secure medications in their rooms. Revise the medication management policy to include securing all medications kept in patient rooms.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 28–35, for the full text of the Directors' comments.) We consider recommendation 15 closed and will follow up on the planned actions for the open recommendations 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 eight activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- MH RRTP

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 2015 and FY 2016 through October 26, 2015, and inspectors conducted the review 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 Philadelphia VA Medical Center, Philadelphia, Pennsylvania,* Report No. 13-01974-337, September 27, 2013).

During this review, we presented crime awareness briefings for 168 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. We distributed an electronic survey to all facility employees and received 437 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Homeless Initiative

The VA identified Philadelphia as having an exceptionally high concentration of homeless veterans. In March 2014, the facility, in partnership with the United States Department of Housing and Urban Development and the United States Interagency Council on Homelessness, launched an effort to end veteran homelessness. Since 2014, 1,000 veterans have been placed in permanent housing, and facility staff placed 70 percent of those veterans. As a result, the metropolitan area aims to end homelessness among veterans in the area.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 31 protected peer reviews, five root cause analyses, 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	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Six profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.	• In seven of the 24 applicable cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee.	**2.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.
	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.		
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

We inspected the surgical (5 East and West), medical (6 East and West), and locked MH (7 East and West) units; the medical and surgical intensive care units; the Emergency Department; the primary care, eye, and dental clinics; the community living center; and the OR. Additionally, we reviewed relevant documents and 20 employee training records, and we conversed with key employees and managers. 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	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Three of nine patient care areas had stained carpeting, accumulations of trash or debris, dust, and dirt. • Three of nine patient care areas contained damaged furniture. • Four of nine patient care areas had stained ceiling tiles.	**3.** We recommended that facility managers ensure patient care areas are clean, damaged furniture is repaired or removed from service, and stained ceiling tiles are replaced and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on medication administration reviewed, which required labeling multi-dose vials with expiration dates of 28 days after the vials were opened or initially used. • Pharmacy Service labeled unopened multi-dose insulin vials with expiration dates of 28 days after the vials were provided to the patient care area. This could potentially lead to unused vials being discarded.	**4.** We recommended that the facility comply with local policy for labeling multi-dose vials with expiration dates after initial use and that facility managers monitor compliance.
	Areas Reviewed for Dental Clinic		
X	Dental clinic employees completed bloodborne pathogens training within the past 12 months.	• Two of 10 dental clinic employees did not have documentation of bloodborne pathogens training during the past 12 months.	**5.** We recommended that dental clinic managers ensure all dental clinic employees complete bloodborne pathogens training annually and monitor compliance.
X	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.	• Three of 10 dental clinic employees did not have documentation of hazard communication training on chemical classification, labeling, and safety data sheets.	**6.** We recommended that dental clinic managers ensure all dental clinic employees complete hazard communication training on chemical classification, labeling, and safety data sheets and monitor compliance.

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees who routinely compound non-emergent sterile products. Additionally, we inspected two areas where sterile products are compounded. 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	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
X	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.	• The facility did not store hazardous compounded medications separately from other inventory.	**7.** We recommended that facility managers ensure compounded hazardous medications are stored separately from other inventory and monitor compliance.
X	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.	• There was no documentation of weekly testing of the chemotherapy pharmacy emergency eyewash station for 2 of the 8 weeks reviewed.	**8.** We recommended that facility managers ensure the emergency eyewash station in the chemotherapy pharmacy has documented weekly testing and monitor compliance.
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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	Recommendations
X	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.	• Facility policy did not address scheduling patient discharges early in the day.	**9.** We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.
X	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision	• The facility's temporary bed locations policy did not include: o Upholding the standard of care while patients are in temporary bed locations o Medication administration o Meal provision	**10.** We recommended that the facility revise its temporary bed locations policy to include upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision.
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.	• Twelve EHRs (35 percent) did not contain documentation that clinicians validated patients and/or caregivers understanding of the discharge instructions provided.	**11.** We recommended that clinicians validate patients' and/or caregivers' understanding of the discharge instructions provided.
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for seven CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. 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	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 32 randomly selected patients who had an acute care admission January 1–December 31, 2014. 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	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.		
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. 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	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Fourteen of the 15 applicable training records contained no evidence of suicide prevention training within 12 months of being hired. • Eight of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**12.** We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility completed required reports and reviews regarding patients who attempted or completed suicide.	• The facility did not complete all required reports for patients who attempted or completed suicide during the time period July 1, 2014–June 30 2015.	**13.** We recommended that the facility complete the required reports regarding patients who attempt or complete suicide and that facility managers monitor compliance.
	Clinicians assessed patients for suicide risk at the time of admission.		
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In five of the 16 applicable EHRs, clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**14.** We recommended that clinicians ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the domiciliary, and conversed with key employees. 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.

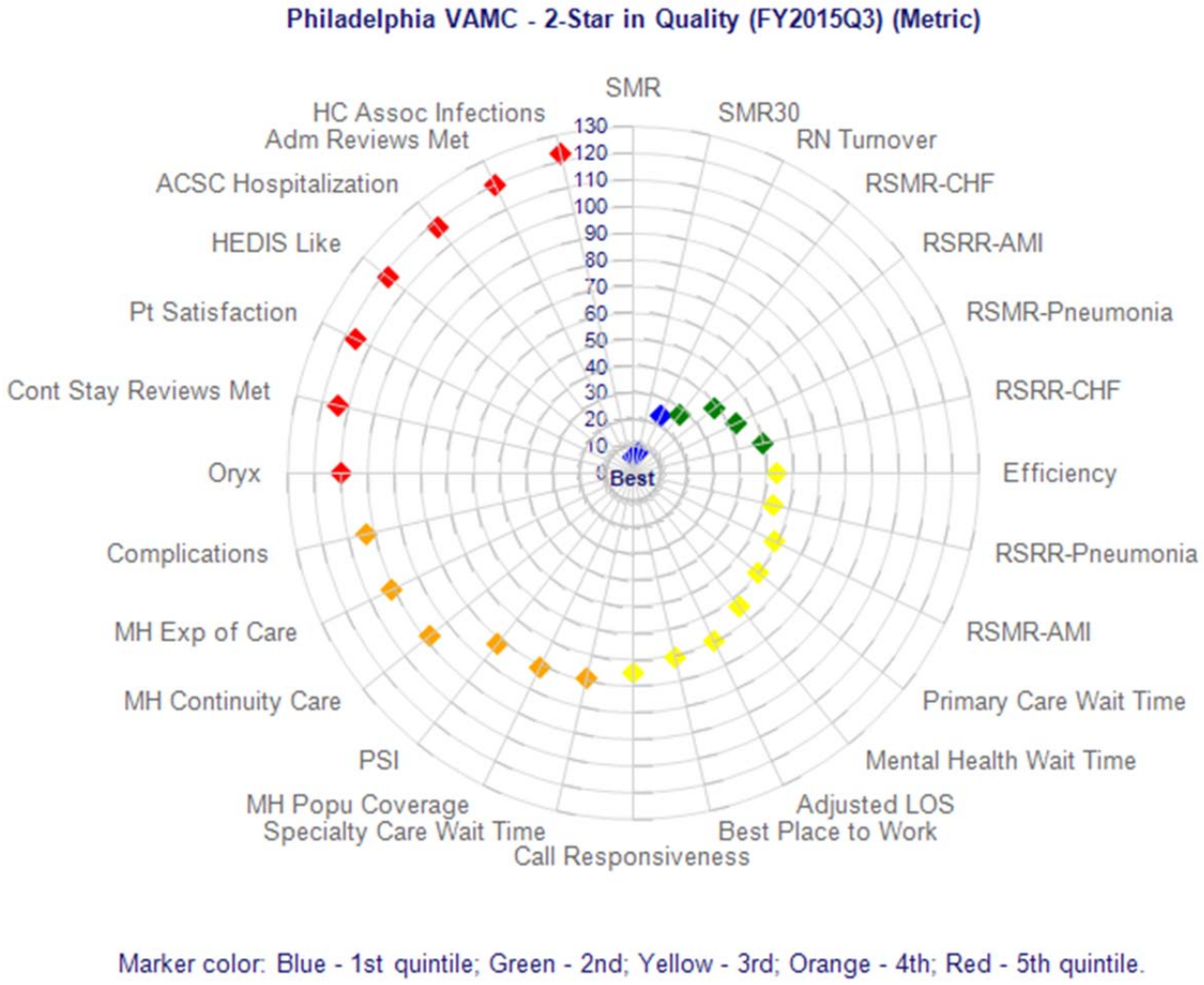
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
X	Appropriate fire extinguishers were available near grease producing cooking devices.	• The domiciliary teaching kitchen, which was used by residents, did not have a Class K fire extinguisher available.	**15.** We recommended that the domiciliary teaching kitchen have a Class K fire extinguisher available.
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
X	Residents secured medications in their rooms.	• Three resident rooms contained unsecured medications.	**16.** We recommended that domiciliary program managers ensure residents secure medications in their rooms and monitor compliance.
X	The facility complied with any additional elements required by VHA or local policy.	Facility medication policy reviewed: • Although VHA requires all medications kept in patient rooms to be secured, facility policy stated that residents could keep medications ordered by a provider unlocked on a bedside stand.	**17.** We recommended that facility managers revise the medication management policy to include securing all medications kept in patient rooms.

Facility Profile (Philadelphia/642) FY 2016 through November 2016[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$48.4
Number of:	
• **Unique Patients**	24,744
• **Outpatient Visits**	63,577
• **Unique Employees**[2]	2,057
Type and Number of Operating Beds:	
• **Hospital**	143
• **Community Living Center**	240
• **MH**	40
Average Daily Census:	
• **Hospital**	92.2
• **Community Living Center**	55.6
• **MH**	17.5
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Fort Dix/642GA Horsham/642GC Sewell/642GD Camden/642GF
VISN Number	4

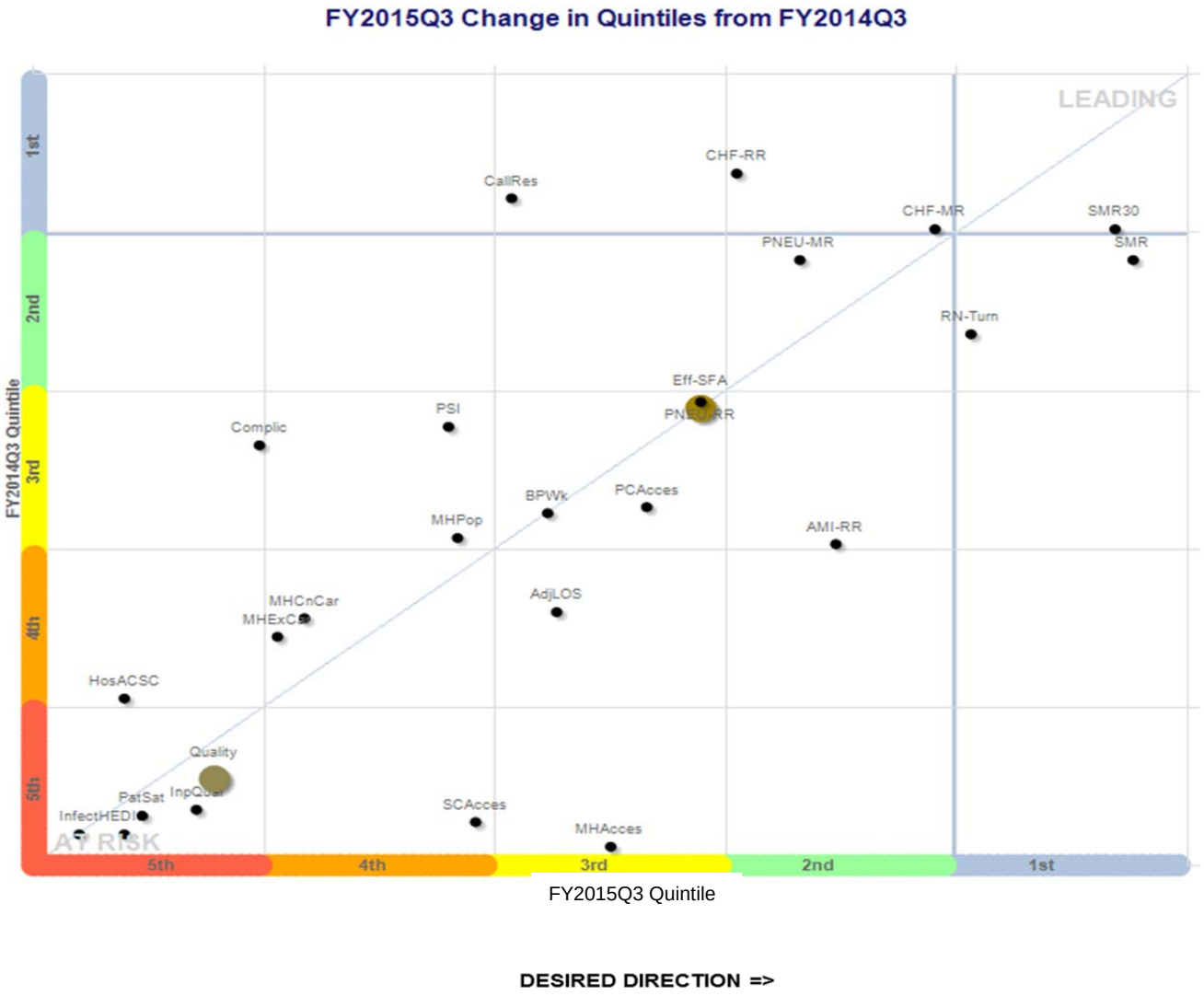
[1] All data is for FY 2016 through November 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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 Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 11, 2015

From: Interim Network Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, PA**

To: Director, Washington, DC Regional Office of Healthcare Inspections (54DC)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed the response provided by the Corporal Michael J. Crescenz VA Medical Center and I am submitting to your office as requested. I concur with all responses and target dates.

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Quality Management Officer at 412-822-3294.

William H. Mills

Attachment

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 10, 2015

From: Director, Corporal Michael J. Crescenz VA Medical Center (642/00)

Subject: **CAP Review of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, PA**

To: Interim Director, VA Healthcare (10N4)

Thank you for the opportunity to review the draft report on the Combined Assessment Program (CAP) Review at the Corporal Michael J. Crescenz VAMC, Philadelphia, PA.

I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)
DANIEL D. HENDEE, FACHE
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 facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: On December 3, 2015, re-education was provided to all Service Chiefs responsible for performing OPPEs. Local policy and Bylaws require all providers have an OPPE review completed every 6 months. A monitoring tool will be utilized to ensure the consistent review of OPPE data every 6 months. The OPPE process will be audited monthly in each service. Audit results will be reported at the Professional Standards Board (PSB) meeting and approved at the Medical Executive Board meeting until there are 3 consecutive months at or greater than 90% compliance.

Recommendation 2. We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: Peer Review Committee (PRC) Meeting minutes will document the actions to be taken as recommended by the committee members. These actions will be carried over in the minutes until completion. Actions will be reviewed and updated each month and will be clearly denoted as "Open" or "Closed." Results of monitoring will be communicated at the Medical Executive Board meeting.

Recommendation 3. We recommended that facility managers ensure patient care areas are clean, damaged furniture is repaired or removed from service, and stained ceiling tiles are replaced and monitor compliance.

Concur

Target date for completion: May 1, 2016

Facility response: To ensure cleanliness, repair of damaged furniture and replacement of stained ceiling tiles, Environmental Management Service (EMS) and Facility

Management Service (FMS) will perform daily inspections of patient care areas utilizing a standardized checklist. Significant findings will be communicated at the Daily Operations Meeting. EMS and FMS developed an inspection program to ensure facility maintenance issues are addressed in a timely manner. All open items will be tracked until closed. Compliance with the maintenance schedule will be monitored. Monitoring results will be reported until there are three consecutive months of 90% or greater compliance. Results of this monitoring will be reported monthly to the Environment of Care (EOC) Committee.

Recommendation 4. We recommended that the facility comply with local policy for labeling multi-dose vials with expiration dates after initial use and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: Medication Administration MCM #11-03 has been revised to include current process for labelling multi-dose vials. Multi-dose vials for insulin will be labeled with a twenty-eight (28) day expiration upon opening or dispensing from pharmacy. Unopened vials will be re-dated on a weekly basis to show the adjusted 28-day expiration by pharmacy or the manufacturer recommended expiry date if shorter. The pharmacy compliance manager will sample 30 vials and will monitor until there are three consecutive months at or greater than 90% compliance.

Recommendation 5. We recommended that dental clinic managers ensure all dental clinic employees complete bloodborne pathogens training annually and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: All dental clinic employees will be sent a reminder that bloodborne pathogen training needs to be completed annually in the Talent Management System (TMS). Compliance with training will be reported at the Environment of Care Committee until 100% is attained.

Recommendation 6. We recommended that dental clinic managers ensure all dental clinic employees complete hazard communication training on chemical classification, labeling, and safety data sheets and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: All dental clinic employees will receive a reminder that hazard communication training on chemical classification/labeling/safety data sheets training

needs to be completed in the Talent Management System (TMS). Compliance will be reported at the Environment of Care Committee until 100% is attained.

Recommendation 7. We recommended that facility managers ensure compounded hazardous medications are stored separately from other inventory and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: On December 4, 2015, all pharmacy staff competent to compound hazardous medications were trained and educated on the ASHP Handling Hazardous Drugs Training. Special emphasis was given on how to store hazardous medications distinctly separate from other medications. The pharmacy quality and compliance program manager will monitor compliance until 100% compliance is sustained for three consecutive months.

Recommendation 8. We recommended that facility managers ensure the emergency eyewash station in the chemotherapy pharmacy has documented weekly testing and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: Staff were re-educated on accurately completing the weekly emergency eyewash documentation. Monitoring will occur until there is 100% compliance for three consecutive months.

Recommendation 9. We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.

Concur

Target date for completion: May 1, 2016

Facility response: MCM #122-11 "Discharge Planning" is being revised to include facility support and prioritization of early discharges. Existing procedures and new initiatives that support earlier times of discharge have been reviewed. These procedures include daily multidisciplinary discharge planning rounds with anticipated discharge planning for the following day as a standard agenda item. Physician-Utilization Management rounding was initiated and will occur daily. There will be identification of anticipated discharges on the Bed Management System (BMS) to facilitate communication regarding pending discharges and utilization of an 'anticipated discharge order' that identifies pending needs prior to discharge readiness.

The Chief of Staff office will monitor that discharges are scheduled earlier in the day as evidenced by the time the discharge order was written. Results of monitoring will be reported monthly at the Medical Executive Committee (MEC). Monitoring will continue until there have been 3 consecutive months of earlier average time of day that discharge orders were written.

Recommendation 10. We recommended that the facility revise its temporary bed locations policy to include upholding the standard of care while patients are in temporary bed locations, medication administration, and meal provision.

Concur

Target date for completion: April 1, 2016

Facility response: In September 2015 MCM# 118-17, Care for Patients in Temporary Bed Locations was revised and approved to include upholding the standard of care while patients are in temporary bed locations as it relates to medication administration and meal provision. MCM changes were communicated to staff and the MCM was implemented in October 2015. Compliance with policy revisions will be reported monthly to Patient Care Executive Board until 90% or greater compliance is achieved for three consecutive months.

Recommendation 11. We recommended that clinicians validate patients' and/or caregivers' understanding of the discharge instructions provided.

Concur

Target date for completion: April 1, 2016

Facility response: The Discharge Instruction and Summary was revised to ensure clinicians document and validate patients' and/or caregivers understanding of the discharge instructions provided. 50 charts from all areas of the organization will be monitored monthly. This will continue until compliance is 90% or greater for three consecutive months. Monitoring results will be reported in Medical Executive Committee (MEC).

Recommendation 12. We recommended that the facility ensure new employees complete suicide prevention training and new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: On November 4, 2015, the Suicide Prevention Coordinator (SPC) was added to the e-mail distribution group which sends out notification of new hires. On December 3, 2015, a process was initiated in which all non- clinical new hires will be

assigned S.A.V.E training and complete suicide prevention training within 12 months. New clinical staff will be assigned to complete suicide risk management training within 90 days of hire through the Talent Management System (TMS). The SPC will monitor compliance with DUSHOM Memo dated June 25, 2008 regarding Suicide Awareness Training. Reports will be generated from TMS regarding suicide prevention and suicide risk management and sent to SPC on a monthly basis. Results of monitoring will be reported at Daily Operations Meeting until there is 100% compliance. SPC will incorporate this monitoring into Suicide Prevention Performance Improvement Activities.

Recommendation 13. We recommended that the facility complete the required reports regarding patients who attempt or complete suicide and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: SPC will ensure that all required reporting and/or reviews regarding patients who attempt or complete suicide are completed. The SPC will monitor required documents until compliance of 100% compliance is sustained for three consecutive months. SPC will report compliance at Daily Operations Meeting.

Recommendation 14. We recommended that clinicians ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: On December 3, 2015, all Suicide Prevention Clinical Staff were re-educated on the requirement to provide patients and/or family members with a Suicide Safety Plan for patients at high-risk for suicidality. The SPC will monitor compliance until 100% compliance is sustained for three consecutive months. SPC will report compliance at the Daily Operations Meeting.

Recommendation 15. We recommended that the domiciliary teaching kitchen have a Class K fire extinguisher available.

Concur

Target date for completion: Completed November 23, 2015

Facility Response: A “K” fire extinguisher was ordered on November 2, 2015—purchase Order # 642-p61308. The fire extinguisher was installed on November 18th, 2015 in the Therapy Kitchen at the MHRTTP.

Recommendation 16. We recommended that domiciliary program managers ensure residents secure medications in their rooms and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility Response: Medication(s) stored in bedside cabinets in Veterans' rooms have been secured with locks. Security of bedside medications will be monitored through weekly environmental rounding on a minimum of 30 or 100% of cabinets, whichever is greater. Results of monitoring will be reported to the Behavioral Health Leadership Council on a monthly basis until 100% compliance is sustained for three consecutive months.

Recommendation 17. We recommended that facility managers revise the medication management policy to include securing all medications kept in patient rooms.

Target date for completion: April 1, 2016

Facility Response: The MHRTTP Standard Operating Procedure (SOP) and weekly environmental rounding process were revised to assign nursing staff the responsibility for performing the inspection with security observing as a witness. Compliance with the revised policy regarding Environmental Rounding Inspections will be monitored weekly. Results will be reported at the Behavioral Health Leadership Council on a monthly basis until 100% compliance is sustained for three consecutive months.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at **www.va.gov/oig.**

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.