



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 10-01158-190

Combined Assessment Program Review of the Providence VA Medical Center Providence, Rhode Island



July 13, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of February 8–12, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Providence VA Medical Center (the medical center), Providence, RI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 99 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

The CAP review covered eight operational activities and one follow-up review area from the previous CAP review. We made recommendations in six of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP report. For these activities, the medical center needed to:

- Require that QM action plans address identified issues, establish target dates, are tracked to completion, and have post-implementation evaluation.
- Ensure compliance with Veterans Health Administration (VHA) policy pertaining to adverse event disclosure.
- Complete root cause analysis (RCA) action plans timely and consistently evaluate the effectiveness of action items.
- Require that the Peer Review Committee (PRC) track actions through to completion.
- Fully implement the local policy for monitoring the copy and paste functions in the electronic medical record.
- Document and implement a plan to address delivery of care to patients in temporary bed locations.
- Ensure that cardiopulmonary resuscitation (CPR) certification be maintained and tracked and that the local policy reflects actions to be taken when CPR certification expires.
- Ensure that Supply, Processing, and Distribution (SPD), operating room (OR), and endoscopy suite personnel comply with VHA policy regarding the use of personal protective equipment (PPE).

- Implement interim measures to ensure appropriate airflow in the SPD area until corrective measures are completed.
- Require that staff conduct and document dialysate testing.
- Ensure that staff identified as at risk of exposure to a harmful atmosphere receive annual training and respirator fit testing.
- Ensure that appropriate staff complete bloodborne pathogens training.
- Require that designated Multidisciplinary Safety Inspection Team (MSIT) members consistently participate in mental health (MH) environment of care (EOC) inspections.
- Ensure that all locked MH unit staff and MSIT members receive annual environmental hazards training.
- Require that staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.
- Require that staff provide patients with appropriate written discharge instructions, educate patients regarding discharge instructions, and consistently document these actions.
- Ensure that all required elements in suicide prevention safety plans are consistently documented and that patients and/or their families are given copies of the safety plans.
- Ensure that skin care assessment and interventions are consistently documented.

The medical center complied with selected standards in the following three activities:

- Magnetic Resonance Imaging (MRI) Safety
- Medication Management
- Physician Credentialing and Privileging (C&P)

This report was prepared under the direction of Donna Giroux, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Acting Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 18–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is a primary and secondary health care facility located in Providence, RI, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Hyannis, Nantucket, New Bedford, and Martha's Vineyard, MA, and in Middletown, RI. The medical center is part of VISN 1 and serves a veteran population of about 166,600 throughout Rhode Island and southern Massachusetts.

Programs. The medical center provides a full range of patient care services. Comprehensive health care is provided through primary and specialty care in the areas of medicine, surgery, and psychiatry. The medical center has 73 acute care beds.

Affiliations and Research. The medical center is affiliated with Brown University's Warren Alpert School of Medicine and Boston University's School of Medicine. More than 500 residents, interns, and students are trained at the medical center each year. The medical center also has a dental residency program in affiliation with Rhode Island Hospital. The medical center and Rhode Island College's School of Nursing participate in the VA Nursing Academy.

In fiscal year (FY) 2009, the medical center research program had 145 projects and a budget of \$13 million. Important areas of research included rehabilitation medicine, cardiology, MH, dermatology, neuroscience, substance abuse, health services, and pulmonary disease. Also, the medical center is involved in a multi-center robotic arm project and an initiative to investigate ways to improve access to care for homeless veterans.

Resources. In FY 2009, medical care expenditures totaled \$162 million. The FY 2010 medical care budget is \$170 million. FY 2009 staffing was 1,035 full-time employee equivalents (FTE), including 81 physician and 178 nursing FTE.

Workload. In FY 2009, the medical center treated 31,630 unique patients and provided 17,111 inpatient days in the hospital. The inpatient care workload totaled

2,903 discharges, and the average daily census was 51. Outpatient workload totaled 332,565 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities and follow-up review area:

- Coordination of Care (COC)
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- Pressure Ulcer Prevention and Management
- QM Program
- Reusable Medical Equipment (RME)
- Suicide Prevention Safety Plans

The review covered medical operations for FY 2009 and FY 2010 through February 12, 2010, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations

from our prior CAP review of the medical center (*Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island, Report No. 07-03173-145, June 12, 2008*). We found that the medical center had not completely corrected the pressure ulcer prevention and management findings.

During this review, we also presented fraud and integrity awareness briefings for 99 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the “Review Activities Without Recommendations” section have no reportable findings.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether managers actively supported the program’s activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed the medical center’s Director, the Chief of Staff (COS), and the QM Coordinator.

A QM program was in place, and managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate structures were in place for 5 of the 12 program activities reviewed.

VHA policy requires that the medical center gather data on patient complaints and provide quarterly reports to managers.¹ Although the medical center gathered patient complaint data, reports were provided to managers only twice in FY 2009. Managers agreed with our finding and implemented changes to ensure that complaint data would

¹ VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

be reported as required. Therefore, we made no recommendation for this finding. However, we identified opportunities for improvement in the following areas.

QM Committee and Oversight. VHA requires that the QM program identify opportunities for improvement and implement and evaluate actions until problems are resolved or improvements are achieved.² Although the medical center tracked and trended data, we did not find evidence of thorough analysis, corrective action planning, and post-implementation evaluation. For example, the medical center frequently cited staff education as a corrective action; however, the provision of education was not tracked to completion nor was it adequate to address the identified issues. Additionally, we noted blank action plans and target dates in the minutes of several committees. Further, the medical center's committee oversight structure was not fully integrated or functional as evidenced by the span of deficiencies across several QM areas.

Adverse Event Disclosure. VHA policy requires the medical center to have a process to ensure that staff disclose harmful adverse events to patients or patient representatives.³ Although the medical center has a policy for institutional disclosure, there was no process to ensure clinical disclosure.

VHA policy also requires that medical center managers receive an annual written report on adverse event disclosures. The medical center did not have evidence of this report for FY 2009.

Patient Safety. The Joint Commission (TJC) and VHA⁴ require that corrective actions identified through RCA⁵ reviews be implemented, monitored for efficacy, and tracked to completion. We found that RCA reviews were generally thorough and completed timely; however, we found pending action plans dating back to FY 2000 that had no documentation of completion. Also, the medical center did not consistently evaluate the effectiveness of the implemented action items.

² VHA Directive 2009-043, *Quality Management Systems*, September 11, 2009.

³ VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.

⁵ An RCA is an in-depth analysis of an adverse event to determine reasons why the event occurred and to develop corrective actions to prevent future occurrences.

PRC. VHA policy requires that the PRC identify opportunities for improvement during the peer review process and monitor corrective actions until they are completed.⁶ Although the medical center tracked the number of completed peer reviews, the number of peer reviews not completed timely, and the number of changes from one level to another, we did not find evidence that action items were tracked to completion. The PRC sent this information to the services for action, but corrective action plans for improvement were not documented or implemented, and any actions taken were not monitored.

Medical Record Reviews. VHA policy requires that the medical center have a process for monitoring the copy and paste functions in the electronic medical record.⁷ Although VHA's requirement for monitoring has been in place since 2006, the medical center's policy was in draft, and the process was not yet implemented.

System Redesign/Patient Flow. TJC requires that the medical center document a plan for the care of patients admitted to temporary bed locations. We found that the medical center did not have a documented plan to address the delivery of care to patients in temporary bed locations, such as the emergency department (ED).

CPR. VHA requires that each medical center have a process in place to ensure that designated clinically active staff have current CPR certification.⁸ We were told that the medical center had implemented a software program to track CPR certification; however, the software program was not effective. We found that only 103 (76 percent) of 135 selected staff had current CPR certification. Additionally, the local policy did not specify actions to be taken when required certification was not maintained.

Recommendation 1

We recommended that the VISN Director ensure that the Acting Medical Center Director requires that QM action plans address identified issues, establish target dates, are tracked to completion, and have post-implementation evaluation.

⁶ VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

⁸ VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

- Recommendation 2** We recommended that the VISN Director ensure that the Acting Medical Center Director requires compliance with VHA policy pertaining to adverse event disclosure.
- Recommendation 3** We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff complete RCA action plans timely and consistently evaluate the effectiveness of action items.
- Recommendation 4** We recommended that the VISN Director ensure that the Acting Medical Center Director requires that the PRC track actions through to completion.
- Recommendation 5** We recommended that the VISN Director ensure that the Acting Medical Center Director requires full implementation of the local policy for monitoring the copy and paste functions in the electronic medical record.
- Recommendation 6** We recommended that the VISN Director ensure that the Acting Medical Center Director requires documentation and implementation of a plan to address delivery of care to patients in temporary bed locations.
- Recommendation 7** We recommended that the VISN Director ensure that the Acting Medical Center Director requires that CPR certification be maintained and tracked and that the local policy reflects actions to be taken when CPR certification expires.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. All committee chairpersons will review QM action plan requirements. Action plans will be documented in minutes using the VISN template, and QM will monitor minutes for compliance. The medical center is developing a clinical disclosure template. The patient safety manager and risk manager will identify cases appropriate for disclosure, confer with providers to determine the need for clinical disclosure, and track and trend the data.

A formal tracking system has been developed to track and trend RCA actions and outcomes. Service chiefs will document completed peer review actions in a memorandum to the COS. The COS will document completion of remediation actions for providers assigned a final PRC level

of greater than 1 and will track, trend, and report issues identified by the PRC on a monthly basis.

The medical center has initiated tracking and trending of the copy and paste functions. Trends will be reported to the Medical Records Committee. A policy for surge capacity is being developed, and education will be provided. Local policy now addresses CPR certification and the actions to be taken when certification expires. The Education Department will maintain a certification roster and monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The medical center's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and TJC's standards.

We inspected SPD, the OR, and the endoscopy suite. We determined that the medical center had established appropriate guidelines and monitored compliance with those guidelines.

VA policy requires that SPD meet specific temperature and humidity levels.⁹ During our tour of the SPD area, we found that temperature and humidity levels exceeded standards and were not monitored daily. While we were onsite, the medical center corrected the temperature and humidity levels and implemented a process and form to document temperature and humidity. Therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

PPE. VHA policy requires the use of PPE when working with chemicals used for decontamination of equipment and high-level disinfection.¹⁰ In addition, the use of PPE is required when working with medical devices that have been

⁹ VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.

¹⁰ VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

in contact with a patient's sterile tissue or mucus membranes. We found that PPE was not consistently used in the SPD area, the OR, or the endoscopy suite.

Air Control. VA policy requires negative pressure airflow in SPD and other decontamination areas to minimize the movement of microorganisms from dirty areas to clean areas.¹¹ We found that the SPD decontamination area had a door leading to an outside hallway. When this door is opened, the negative pressure in this area is lost. We were told that the medical center had identified this prior to our visit and has plans to correct the problem.

Recommendation 8 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that SPD, OR, and endoscopy suite personnel comply with VHA policy regarding the use of PPE.

Recommendation 9 We recommended that the VISN Director ensure that the Acting Medical Center Director implements interim measures to ensure appropriate airflow in the SPD area until corrective measures are completed.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. The medical center has developed an evaluation, tracking, and trending system for proper PPE use. Results will be reported monthly to the RME Committee. An exhaust ventilation system has been installed in the SPD decontamination area to ensure negative pressure. The implementation plans for Recommendation 8 are acceptable, and we will follow up on the planned actions until they are completed. The corrective action for Recommendation 9 is acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, TJC's, National Center for Patient Safety, OSHA, and National Fire Protection Association standards.

We inspected the hemodialysis (dialysis) unit, the ED, the special population clinic, and all inpatient units, including the

¹¹ VA Handbook 7176.

locked MH unit. The medical center maintained a generally clean and safe environment.

Although required by TJC, we found that staff did not ensure that all utility rooms were secured against intrusion by unauthorized personnel and that empty cardboard boxes were kept off the floor. Additionally, OSHA requires full oxygen tanks to be stored separately from empty tanks; however, we found some full tanks stored with empty tanks. The medical center took action to correct these issues while we were onsite; therefore, we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

Dialysis Unit. The Association for the Advancement of Medical Instrumentation requires monthly biological testing of water and dialysate¹² used for dialysis. We reviewed 12 months of culture reports and found that staff documentation of biological testing did not include dialysate testing.

Respirator Fit Testing. OSHA requires that staff identified as at risk of exposure to a harmful atmosphere, such as tuberculosis, be trained and fit tested for N95 respirators. We found that 9 (41 percent) of 22 at risk employees had not received the annual training and respirator fit testing.

Bloodborne Pathogens. Local policy requires that bloodborne pathogens training be provided for designated employees at the time of initial employment and annually thereafter. We examined the training records of employees assigned to an inpatient unit and an outpatient clinic and found that 4 (15 percent) of the 27 training records did not have documentation of annual training.

Inspection Team. VHA policy requires that each medical center with a locked MH unit have an MSIT consisting of specific representatives who conduct quarterly MH EOC inspections.¹³ Although the medical center conducted quarterly MH EOC inspections, we found that some designated MSIT representatives did not consistently participate in the inspections.

¹² Liquid used to pull toxins from the blood during dialysis.

¹³ Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

VHA policy also requires that annual training on the identification of environmental hazards that pose a risk to suicidal patients be provided to employees assigned to locked MH units and members of the MSIT. We did not find evidence that the medical center provided the required annual environmental hazards training for locked MH unit staff or MSIT members.

Recommendation 10 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff conduct and document dialysate testing.

Recommendation 11 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff identified as at risk of exposure to a harmful atmosphere receive annual training and respirator fit testing.

Recommendation 12 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that appropriate staff complete bloodborne pathogens training.

Recommendation 13 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that designated MSIT members consistently participate in MH EOC inspections.

Recommendation 14 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all locked MH unit staff and MSIT members receive annual environmental hazards training.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. Dialysis nursing staff are conducting dialysate testing. Results are being tracked, trended, and reported to the Infection Control Committee. Staff identified as at risk for exposure to a harmful atmosphere will be enrolled in the respiratory protection program. The Education Department will monitor staff compliance with bloodborne pathogens training and will report results monthly to medical center leaders. The medical center has established and trained an MSIT. The MSIT will participate in EOC rounds as required. Additionally, MSIT members and MH unit staff have completed the required annual environmental hazards training. The implementation plans for Recommendations 10–13 are acceptable, and we will follow

up on the planned actions until they are completed. The corrective action for Recommendation 14 is acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and TJC's requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the medical center had an appropriate transfer policy. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation.¹⁴ We reviewed transfer documentation for 10 patients transferred from the medical center's ED, intensive care unit, and telemetry unit to other facilities. We found that providers did not document all required information for any of the 10 patients. Missing information included documentation of the medical and/or behavioral stability of the patient, time of the transfer, and consent to transfer.

VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program. We did not find evidence that patient transfers were monitored and evaluated as part of the QM program.

Discharges. VHA requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions.¹⁵ In addition, TJC's standards require that clinicians provide patients with written discharge instructions. We reviewed the medical records of 20 discharged patients and found deficiencies in 15 (75 percent) of the records as follows:

- Two records had discharge diet instructions that were inconsistent with previous inpatient orders. For example,

¹⁴ VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

¹⁵ VHA Handbook 1907.01.

discharge instructions for a regular diet were given to patient with diabetes instead of a modified diet as previously ordered.

- Six records did not have documentation that written discharge instructions were provided to the patients.
- Seven records did not have evidence that staff provided discharge diet education to patients or caregivers.

Recommendation 15

We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Recommendation 16

We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff provide patients with appropriate written discharge instructions, educate patients regarding discharge instructions, and consistently document these actions.

The VISN and Acting Medical Center Directors agreed with the findings and recommendations. Service chiefs have reviewed the inter-facility policy and template. Eighty-five percent of all transferred patients' records will be reviewed monthly, and results will be tracked, trended, analyzed, and reported to the service chiefs and QM. Ten discharged patients' charts will be reviewed monthly, and results will be tracked, trended, analyzed, and reported to the Director of Case Management. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

**Suicide Prevention
Safety Plans**

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how

patients can access professional help 24 hours a day, 7 days a week.¹⁶

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.¹⁷ The review identified that safety plans were not comprehensive, were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of 10 patients assessed to be at high risk for suicide and identified the following area that needed improvement.

Inadequate and/or Missing Safety Plans. In 1 (10 percent) of the 10 records, we found that the safety plan did not contain all of the required elements, and in 9 (90 percent) of the 10 records, we could not find evidence to support that the patients and/or families were provided copies of the plans. Although the medical center has taken steps to address these issues, implementation of the action plan requires further monitoring.

Recommendation 17

We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all required elements in suicide prevention safety plans are consistently documented and that patients and/or their families are given copies of the safety plans.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation. MH providers will develop suicide prevention safety plans that include all required elements and will document the plans. Patients will receive copies. The suicide prevention coordinator will track, trend, analyze, and report results to the Chief of Psychiatry. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Pressure Ulcer Prevention and Management

We followed up on the recommendations regarding pressure ulcer prevention and management from the previous CAP review. In that report, we recommended that skin care interventions be consistently documented and that data

¹⁶ Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

¹⁷ *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*; Report No.09-00326-223; September 22, 2009.

analysis include trending for the effectiveness of skin care interventions.

Since 2005, the medical center has had an established committee for skin care. In December 2009, staff updated skin care protocols. The Wound Care Specialist collects, trends, and analyzes skin care data and interventions and reports the findings quarterly to the QM Service, nursing leadership, and the Clinical Executive Board. Although the medical center had implemented processes to address skin care and treatment, we identified the following area that needed improvement.

Skin Care Assessments and Intervention. We reviewed the medical records of six inpatients who had pressure ulcers in February 2010 and found that four of the six records had inconsistent documentation of skin care assessments and interventions. This is a repeat finding.

Recommendation 18

We recommended that the VISN Director ensure that the Acting Medical Center Director requires that skin care assessments and interventions be consistently documented.

The VISN and Acting Medical Center Directors agreed with the finding and recommendation. Nursing staff will be re-educated on the appropriate skin assessment documentation templates. Twenty charts will be reviewed monthly. The results will be tracked, trended, analyzed, and reported to the Skin Assessment Committee and nursing leadership. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

**Magnetic
Resonance
Imaging Safety**

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by TJC.

The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have been conducted in the MRI area.

Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 9 personnel and found that all had completed required safety training. Also, we reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients.

The medical center had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.¹⁸ We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 medical records we reviewed. Also, although the pharmacy is closed from 6:00 p.m. to 6:00 a.m. daily, we found that the medical center had appropriately provided a qualified pharmacist to answer questions during those hours and had an adequate retrospective review process. We made no recommendations.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.¹⁹ We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 13 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice

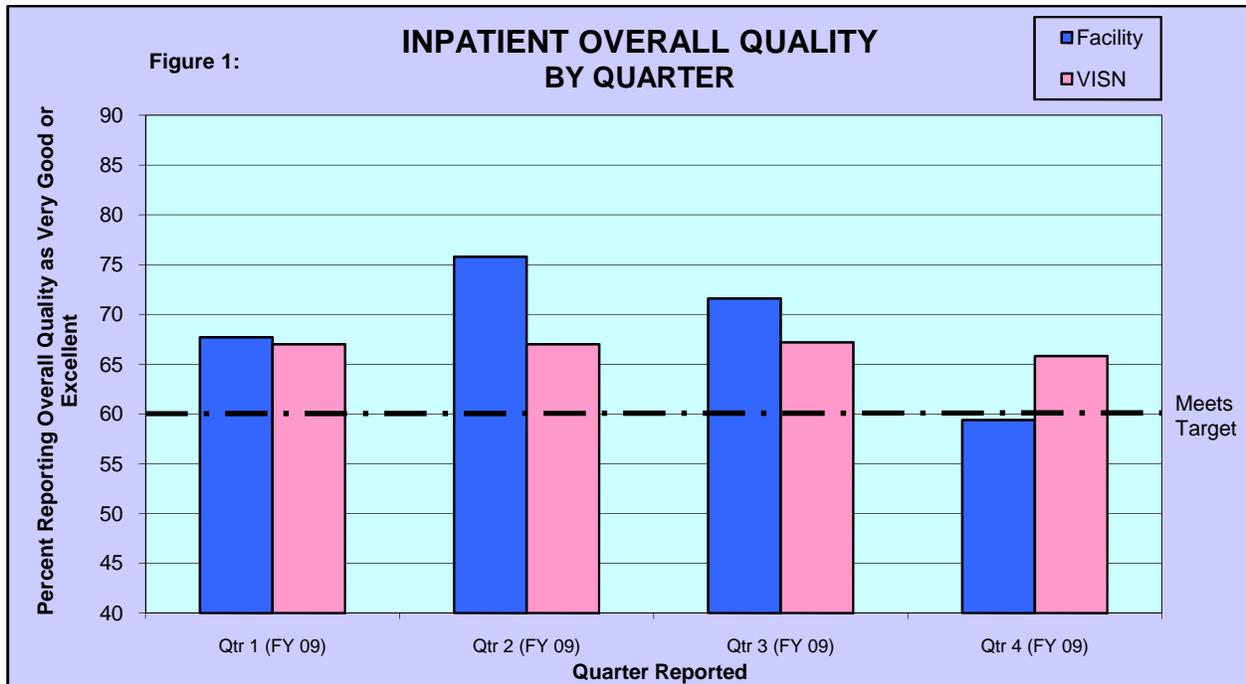
¹⁸ Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

¹⁹ VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

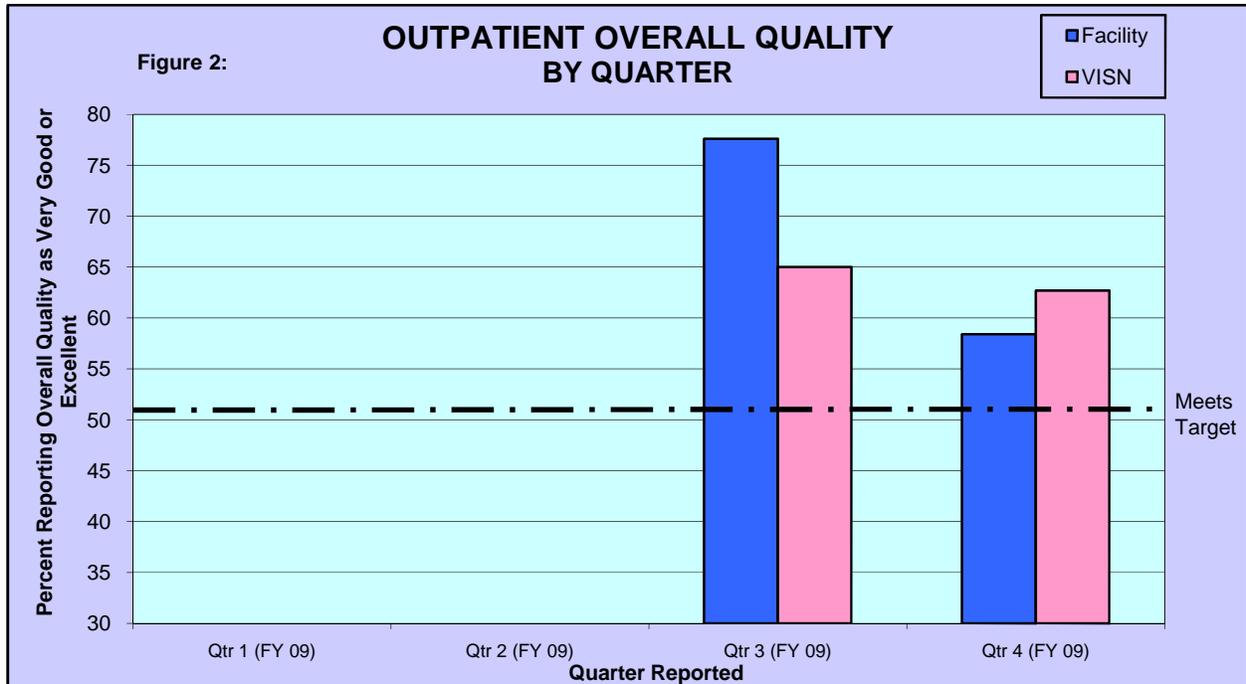
Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

VHA Satisfaction Surveys

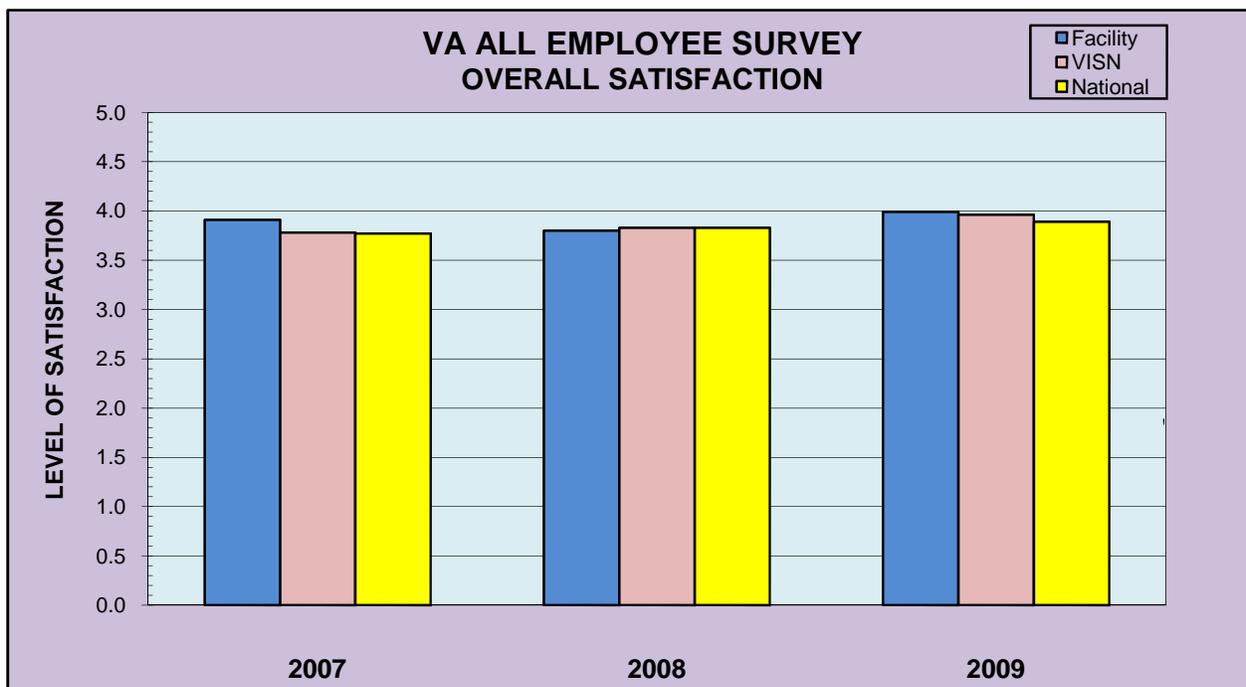
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.²⁰ The target scores are noted on the graphs.



²⁰ Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: May 28, 2010

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

Subject: **Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island**

To: Director Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

I concur with the recommendations from the OIG CAP visit conducted February 8–12, 2010.



Network Director
Director, VA New England Healthcare System
VISN 1

Acting Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: May 24, 2010

From: Medical Center Director (Acting) (650)

Subject: **Combined Assessment Program Review of the Providence VA Medical Center, Providence, Rhode Island**

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

I concur with the recommendations from the OIG CAP visit conducted February 8–12, 2010. The attached responses outline our plan for each recommendation.


MEDICAL CENTER DIRECTOR (Acting)

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that QM action plans address identified issues, establish target dates, are tracked to completion, and have post-implementation evaluation.

Concur.

The QM Department at PVAMC will have a mandatory education meeting with all committee chairs to review the requirements for action plans which are to be included in the minutes of all committees and task forces utilizing the VISN minutes template. The VISN template addresses the action plans for identified issues, establishes target dates, notes tracking to completion, and post-implementation evaluation and documentation. All committee and task force minutes will be monitored by the Department of QM to ensure compliance. The completion date will be August 31st, 2010.

Recommendation 2. We recommended that the VISN Director ensure that the Acting Medical Center Director requires compliance with VHA policy pertaining to adverse event disclosure.

Concur.

The PSM and RM will be using incident reports and occurrence screens to identify cases that may be appropriate for disclosure. Follow-up will involve contacting the involved practitioner to determine if there is a need for clinical disclosure. A clinical disclosure template is being developed to facilitate completion. Tracking, trending, and reporting will be completed by the PSM and RM. This will be completed by June 30th, 2010.

Recommendation 3. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff complete RCA action plans timely and consistently evaluate the effectiveness of action items.

Concur.

Formal tracking for actions/outcomes has been developed. PSM will review all backlog with a completion date of June 30th, 2010.

Recommendation 4. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that the PRC track actions through to completion.

Concur.

The Office of the COS will add to the existing PR spreadsheet a column for tracking completion of Service Chief remediation actions for individual providers assigned a final PRC level > 1. Completed actions will be documented in a memo from the Service Chief to the Chief of Staff. The COS will bring systems issues identified by the PRC to the CEB on a monthly basis. Tracking, Trending and Analysis will be conducted by the COS Office and reported to CEB on a monthly basis. Responsible persons: COS Office. Start date: May 14th, 2010. Completion: Ongoing.

Recommendation 5. We recommended that the VISN Director ensure that the Acting Medical Center Director requires full implementation of the local policy for monitoring the copy and paste functions in the electronic medical record.

Concur.

HIMS Department has initiated tracking and trending of “cut and paste data” from the EMR (CPRS). Trends, analysis, and issues will be reported at Medical Records Committee. Monitoring and reporting is ongoing.

Recommendation 6. We recommended that the VISN Director ensure that the Acting Medical Center Director requires documentation and implementation of a plan to address delivery of care to patients in temporary bed locations.

Concur.

A policy and procedure for surge capacity and delivery of care is currently in the final stages of development. This policy will bridge the patient flow policy and emergency preparedness plan. Formal education and implementation will be completed by June 11th, 2010.

Recommendation 7. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that CPR certification be maintained and tracked and that the local policy reflects actions to be taken when CPR certification expires.

Concur.

Emergency medical care policy has been edited to address mandatory BLS/ACLS certification and actions to be taken when certification expires. Internal processing and maintenance of certification rosters by the

Education Department has been redefined to assure compliance. Monthly monitoring for compliance will be completed by the Education Department and communicated to the QUAD Leadership. The first report was completed May, 2010.

Recommendation 8. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that SPD, OR, and endoscopy suite personnel comply with VHA policy regarding the use of PPE.

Concur.

Endoscopy: A quality monitor is developed for monthly evaluation, tracking and trending of staff wearing full PPE to disinfect the endoscopes. We will also monitor the door being closed for proper ventilation of the air flow. This will be tracked, trended, and analyzed on a monthly basis and reported to the RME Committee.

OR: All operating room nursing staff when working with chemicals used for decontamination of equipment will use the required PPE. All PPE will be removed upon exiting the decontamination room. QA monitoring tool developed to assess compliance.

SPD: QA monitor developed to assess compliance with proper use of PPE in the decontamination room. Deficiencies will be addressed with individual staff.

The above will be fully implemented and one month of monitoring completed by June 30th, 2010.

Recommendation 9. We recommended that the VISN Director ensure that the Acting Medical Center Director implements interim measures to ensure appropriate airflow in the SPD area until corrective measures are completed.

Concur.

The SPD decontamination area has been and continues to remain under negative pressure relative to the clean area as required by the SPD policy. Opening the door to the hall has no effect on the relative airflow in the space from clean area to dirty area. This condition is documented annually by the Medical Center's Industrial Hygienist. The correction the Medical Center was investigating is a best practice to ensure any odors generated by the cleaning processes are maintained in the decontamination room relative to the outside hall area. For that reason on May 19, 2010, an exhaust ventilation system was installed to ensure the decontamination room remains negative relative to the hall.

Recommendation 10. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff conduct and document dialysate testing.

Concur.

Monthly dialysate testing is being conducted by the dialysis nursing staff as recommended by the Association for the Advancement of Medical Instrumentation. Results are tracked and trended and reported to the Infection Control Committee and the monthly Dialysis QI/PI meetings. This has been fully implemented and is ongoing.

Recommendation 11. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff identified as at risk of exposure to a harmful atmosphere receive annual training and respirator fit testing.

Concur

The TB policy is currently being updated by the Infection Control Coordinator. The new policy will specify staff at risk by department. A list of employees at risk will be generated for enrollment in the medical centers Respiratory Protection Program. This enrollment includes training and testing. This will be completed August 31st, 2010.

Recommendation 12. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that appropriate staff complete bloodborne pathogens training.

Concur.

The education department will send the reports from LMS on this required training to services and infection control on a monthly basis. Compliance will be monitored by education and reported to QUAD leadership.

Recommendation 13. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that designated MSIT members consistently participate in MH EOC inspections.

Concur

The multidisciplinary safety and inspection team was established as required by protocol March, 2010. Formal team training conducted. Team members instructed that participation in the EOC rounds is mandatory. Attendance tracked by PSM.

Recommendation 14. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all locked MH unit staff and MSIT members receive annual environmental hazards training.

Concur.

MSIT members and MH unit staff have completed mandatory training. This is an annual training.

Recommendation 15. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Concur.

The interfacility transfer policy has been reviewed with service chiefs. The requirements for documentation are outlined in a template in CPRS and reviewed with the above. To assure compliance, chart review will be conducted monthly on 85% of all patients transferred from the PVAMC. Information will be tracked, trended, and analyzed monthly and sent to service chiefs and QM.

Recommendation 16. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff provide patients with appropriate written discharge instructions, educate patients regarding discharge instructions, and consistently document these actions.

Concur.

The interdisciplinary care planning policy identifies the elements that need to be covered for discharge planning. The action plan to assure compliance will be monitoring 10 charts monthly for these critical elements. The information will be tracked, trended, and analyzed and reported to the Director of Case Management. First reporting will be completed by June 30th, 2010.

Recommendation 17. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that all required elements in suicide prevention safety plans are consistently documented and that patients and/or their families are given copies of the safety plans.

Concur.

All outpatient and inpatient Mental Health Providers will be advised to document the development of a safety plan which incorporates the required elements in the suicide prevention safety plan. A copy is provided to the veteran. This was effective Feb. 16, 2010. The suicide

prevention coordinator will track, trend, and analyze both inpatient and outpatient templates and report to the Chief of Psychiatry. This has been fully implemented and to date there has been 100% compliance.

Recommendation 18. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that skin care assessments and interventions be consistently documented.

Concur.

Nursing staff will be re-educated on the appropriate skin assessment documentation templates. Twenty charts will be reviewed on a monthly basis, tracked, trended, and analyzed, and presented to the Skin Assessment Committee and nursing leadership. The first reporting will be completed June 30th, 2010.

OIG Contact and Staff Acknowledgments

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