



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

Office of Healthcare Inspections

Report No. 08-01089-137

Combined Assessment Program Review of the Coatesville VA Medical Center Coatesville, Pennsylvania



June 4, 2008

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 April 7–11, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Coatesville VA Medical Center (the medical center), Coatesville, PA. 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 613 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered five operational activities and a follow-up review area from the prior CAP. We identified the following organizational strength and reported accomplishment:

- Homeless Women’s Veterans Program.

We made recommendations in three of the activities reviewed and in the follow-up review area from the prior CAP. For these activities and the follow-up review area, the medical center needed to:

- Ensure that visits to Community Residential Care (CRC) Program homes are documented in the electronic medical record.
- Ensure that the CRC Coordinator updates the CRC handbook annually and meets with CRC home operators annually to review the handbook and that these meetings are documented in the electronic medical record.
- Ensure that the CRC Coordinator meets annually with VA Regional Office (VARO) fiduciaries to discuss CRC residents and documents the meetings in the electronic medical record.
- Require the Peer Review Committee (PRC) to meet at least quarterly.
- Require that annual training for controlled substances inspectors is conducted and documented.
- Require that all designated environment of care (EOC) team members participate in all EOC rounds and that documentation of participation is complete.

- Comply with Veterans Health Administration (VHA) policy regarding security measures for protection of research animals.
- Ensure compliance with VHA patient safety standards for training of locked mental health unit staff and Multidisciplinary Safety Inspection Team (MSIT) members and ensure that the MSIT includes the appropriate disciplines.
- Require appropriate staffing of the Urgent Care Clinic (UCC) during all hours of operation.

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

- Computerized Patient Record System (CPRS) Business Rules.
- Survey of Healthcare Experiences of Patients (SHEP).

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

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–19, 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 specialty referral, transitional care, and neuropsychiatric facility located in Coatesville, PA. Primary care and mental health services are provided at two community based outpatient clinics (CBOCs) located in Springfield and Spring City, PA. The medical center is part of VISN 4 and serves a veteran population of 33,562 throughout southeastern Pennsylvania (Chester, Lancaster, Delaware, and Montgomery counties), Delaware, and New Jersey.

Programs. The medical center provides primary care, mental health, and geriatric and extended care services. It has 79 hospital beds, 164 nursing home beds, and 229 domiciliary beds.

Affiliations and Research. The medical center is affiliated with West Chester University, Bryn Mawr College, the University of Pennsylvania, Widener University, Seton Hall University, Drexel University, the University of Hartford, Chestnut Hill College, and several other schools for psychology. In addition, the medical center has affiliations with other colleges and universities to provide training for other disciplines, including social work, nursing, physician assistant, nurse practitioner, medical technician, and chaplain. In fiscal year (FY) 2007, the medical center research program had 21 projects and a budget of \$1.4 million. Important areas of research include animal and human studies focusing on substance abuse, post-traumatic stress disorder, Alzheimer's disease, and epilepsy.

Resources. In FY 2007, medical care expenditures totaled \$146 million. The FY 2008 medical care budget is the same as FY 2007 expenditures. FY 2007 staffing was 1,180 full-time employee equivalents (FTE), including 29.5 physician and 330 nursing FTE.

Workload. In FY 2007, the medical center treated 20,688 unique patients and provided 22,711 inpatient days in the hospital and 52,112 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 3,073 discharges, and the average daily census, including nursing home patients, was 411.2. Outpatient workload totaled 168,607 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:

- CPRS Business Rules.
- CRC Program.
- EOC.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through April 7, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the Coatesville VA Medical Center, Coatesville, Pennsylvania*, Report No. 03-02278-08, October 29, 2003). The medical center had not corrected all health care related conditions in the CRC Program.

During this review, we also presented fraud and integrity awareness briefings for 613 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.

Organizational Strength

Homeless Women’s Veterans Program

The Mary E. Walker House is a 30-bed transitional residence for women veterans who find themselves in difficult life situations and without a home. The program is jointly run by the medical center and the Philadelphia Veterans Multi-Service and Education Center, Inc. Program participants come from all over the United States. Services available through the program include:

- Medical and mental health treatment as a VA outpatient.
- Recovery.
- “Seeking Safety” program.
- Case management and discharge planning.
- Job development and educational opportunities.
- Personal budget development.
- Assistance with VA benefits.
- Linkages to community resources and involvement.

The program provides a safe environment for the women veterans as they learn to deal with addiction and mental health issues. Also, the program teaches them the skills necessary to enable them to return to their communities as productive members.

Results

Review Activities With Recommendations

Community Residential Care Program

The purpose of this review was to follow up on previous CAP review findings in the CRC Program. Since 1951, the VA CRC Program has provided health care supervision to eligible patients who are not in need of acute hospital care but—because of medical and/or psychosocial health conditions—are not able to live independently and have no suitable family or significant others to provide the needed supervision and supportive care. The CRC Program is an important component in VA’s continuum of long-term care. The medical center had corrected most of the deficiencies identified during the prior CAP review; however, the following still needed improvement.

Documentation of Community Residential Care Visits. CRC nurses and social workers are required to make monthly visits to CRC homes and to document these visits in the electronic medical record. We reviewed the electronic medical record documentation for 10 CRC residents. Nine of the 10 residents did not have documentation of the monthly visits in the electronic medical record. The CRC Coordinator informed us that the documentation is done on a paper form, which is kept in the CRC office.

Ongoing Training of Community Residential Care Home Operators. VHA policy requires that the medical center develop a CRC provider’s handbook and distribute it to CRC home operators. This handbook must be updated annually and reviewed with CRC home operators. The CRC Coordinator must sign a statement that this review occurred and place it in CRC Program records. We visited three CRC homes and found that this training was not completed.

Documentation of Annual Meeting with VA Regional Office Representative. For CRC residents who have both VA funding and a VARO fiduciary, an annual meeting is to be held between a representative from the medical center and each fiduciary. We reviewed 10 resident records. Three of the 10 residents had VA funding and a VARO representative as a fiduciary. None of the three records contained documentation that this annual meeting had occurred.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director requires that monthly visits to CRC

homes are documented in each CRC resident's electronic medical record.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the CRC Coordinator update the CRC handbook annually, meet with all CRC home operators annually to review the handbook, and document these meetings in the electronic medical record.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the CRC Coordinator meet annually with each VARO representative who acts as a fiduciary for a CRC resident to discuss the resident's finances and that this meeting is documented in the electronic medical record.

The VISN and Medical Center Directors concurred with the findings and recommendations and have developed a template progress note entitled "CRC Monthly Inspections" to facilitate documentation of the monthly CRC visits. The CRC Coordinator is updating the CRC handbook and will review the updated handbook with CRC home operators and document the meeting in the electronic medical record. In addition, the CRC Coordinator and involved case managers will meet annually with VARO representatives of residents who receive VA funding. These meetings will be documented in individual resident's electronic medical records. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

**Quality
Management**

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Director, the Chief of Staff, and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care in the medical center. However, we identified the following area that needed improvement.

Peer Review. The peer review process did not include all components required by VHA policy.¹ Peer review is a confidential, non-punitive, and systematic process to evaluate the quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,² with subsequent PRC evaluation and concurrence with the findings. The medical center completed all peer reviews within the required timeframes.

VHA policy requires that the PRC meet at least quarterly. The medical center PRC met four times during the year but did not meet quarterly, as required by the directive.

Recommendation 4

We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC meet at least quarterly.

The VISN and Medical Center Directors concurred with the finding and recommendation and have developed a schedule for quarterly PRC meetings. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Pharmacy Operations

The purpose of this review was to evaluate whether the medical center had adequate controls to ensure the security and proper management of controlled substances and the pharmacies' internal physical environments. We also evaluated whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and controlled substances security, and we assessed whether the medical center's policies and practices were consistent with VHA regulations. We inspected the inpatient and outpatient pharmacies for security, EOC, and infection control (IC) concerns, and we interviewed Pharmacy Service and Police and Security Service personnel. Additionally, we evaluated whether clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

¹ VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

² Peer review levels: Level 1 – Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of the pharmacies and controlled substances. Controlled substances inspections were conducted according to VHA regulations, and managers reported all controlled substance diversions or suspected diversions to the OIG. The pharmacies' internal physical environments were secure, clean, and well maintained.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions. Elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.

Managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

Training. Annual training for inspectors was not consistent. Five of 24 inspectors did not receive the required annual training. We reviewed the training records of all 25 inspectors, including that of the Controlled Substances Coordinator, and found that only 20 of the 25 records documented the required annual training.³

Recommendation 5

We recommended that the VISN Director ensure that Medical Center Director requires that annual training for controlled substances inspectors is conducted and documented.

The VISN and Medical Center Directors concurred with the finding and recommendation. All controlled substances inspectors have completed annual training. The

³ VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004.

implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Environment of Care

The purpose of this review was to determine if the medical center maintained a safe and clean health care environment. The medical center is required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission standards. The IC program was evaluated to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance.

We inspected the locked behavioral health units; the acute medical unit; the medical admissions unit; the animal research facility; primary care clinics; and the long-term care units, including hospice. The medical center maintained a generally clean environment. The IC program monitored and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. The following conditions required management attention.

Environment of Care Rounds. EOC rounds by a facility inspection team allow each discipline participating on the team to identify and correct discrepancies, unsafe working conditions, and OSHA regulatory violations. Representation from each discipline enables the team to cover the facility in depth. At the medical center, each discipline has not been represented on EOC rounds, and documentation of attendee/designee participation is difficult to track. For example, prior to 2008, the medical center's two CBOCs were inspected semi-annually without full team participation.

While we were onsite, the EOC rounds team took immediate actions to develop a comprehensive tracking sheet to ensure that all required disciplines participate on EOC rounds. In addition, the Associate Director, who is the EOC Chairperson, will formally appoint a designee to attend EOC rounds when he is unavailable and ensure that attendance of the designee is appropriately documented.

Animal Research. Animal research contributes immeasurably to advancements in medical science. VA actively supports the use of animals in research to provide hope for veterans suffering from diseases that currently lack

cures or effective treatment. However, the use of animals in VA research is a privilege granted with the understanding and expectation that such research is conducted according to the highest ethical and legal standards.

The Animal Care Facility (ACF) was inspected for EOC and Interim Life Safety Measures compliance due to construction onsite. Signage on the ACF door stated that anyone visiting the ACF must sign in. The EOC rounds team was not asked to sign in when they entered the facility or sign out when they left. During the inspection, it was noted that the back door to the ACF was propped open to allow construction workers access to the facility. Not requiring the EOC team to sign in and out of the ACF and propping a secured door open are lapses in security.⁴ The medical center needs to strengthen the security measures used to protect the research animals from unauthorized personnel.

Locked Mental Health Units. VHA's mental health EOC checklist and protocol is used to identify environmental safety concerns on locked mental health units. The protocol directs the establishment of an MSIT. Prior to conducting rounds on a quarterly basis, the team and staff working on the locked mental health units must be trained to identify environmental hazards that pose a threat to suicidal patients. All team findings, actions, and outcomes from these rounds should be tracked on the "Risk Assessment and Abatement Tracking" spreadsheet.

We found that although the team and the staff on Units 58A and 58B have implemented changes to protect their patient population, they have not received the required training to identify environmental hazards. Also, the team lacked the following staff members:

- Psychiatrist.
- Non-psychiatric nurse manager.
- Mental health worker.
- Non-mental health employees.

Urgent Care Clinic. The UCC provides ambulatory medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or psychiatric illness and/or minor injuries. The medical center

⁴ VHA Handbook 1200.7, *Use of Animals in Research*, May 27, 2005.

Director is responsible for establishing the hours of operation and ensuring that the clinic is appropriately staffed and equipped at all times. Staff is required to receive requisite training for the scope of practice in the clinic and for initial stabilization of acute emergencies.⁵

The medical center's UCC is open 24 hours per day, 7 days per week. A physician from the medical center is available on call any time the UCC is open. During business hours, the UCC is staffed by a mid-level provider (for example, a nurse practitioner), registered nurses (RNs), and support staff. Off hours, the clinic is staffed with a medical administrative assistant (MAA). The MAA has access to a physician and RN on call, but they are not located in the clinic. In addition, the Medical Emergency Response Team (MERT) responds to code blue calls.

The MAA is the first person a veteran encounters when seeking medical care in the off hours. The MAA must decide whether to call the RN, physician, or the MERT team and is thus making triage decisions. Although UCCs are not designed to provide the full spectrum of emergency medical care, they are expected to provide initial stabilization of acute emergencies. If the UCC is open 24 hours per day, 7 days per week, it must be staffed appropriately, and the level of services provided must be congruent with the capabilities, capacity, and function of that UCC.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that documentation of participation is complete.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director complies with VHA policy on security measures for protection of research animals.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director complies with VHA policy on patient safety standards for training of locked mental health unit staff and MSIT team participants and ensures that the MSIT team includes the appropriate disciplines.

⁵ VHA Directive 2007-043, *Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities*, December 18, 2007

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires appropriate staffing of the UCC during all hours of operation.

The VISN and Medical Center Directors concurred with the findings and recommendations and have implemented the following actions: (1) The sign-in sheet was revised, and each discipline has submitted the name(s) of their qualified delegate(s); (2) The ACF closed and locked the basement doors, and the contractor now enters from the front security door, signs in, and is monitored by research staff when working in the animal lab area; (3) Newly developed annual training will be completed by psychiatric unit staff and MSIT team participants, and the MSIT team will include all appropriate disciplines; and (4) The Medical Center Director will assure that there is appropriate staffing of the UCC during all hours of operation. The implementation plans are acceptable, and we consider Recommendation 7 closed. We will follow up on the remaining planned actions until they are completed.

Review Activities Without Recommendations

Computerized Patient Record System Business Rules

The health record, as defined by VHA policy,⁶ includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

A communication (software informational patch USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues related to the editing of electronically signed documents in the electronic medical records system. The OI cautioned that “the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed.” On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

⁶ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center's Privacy Officer.

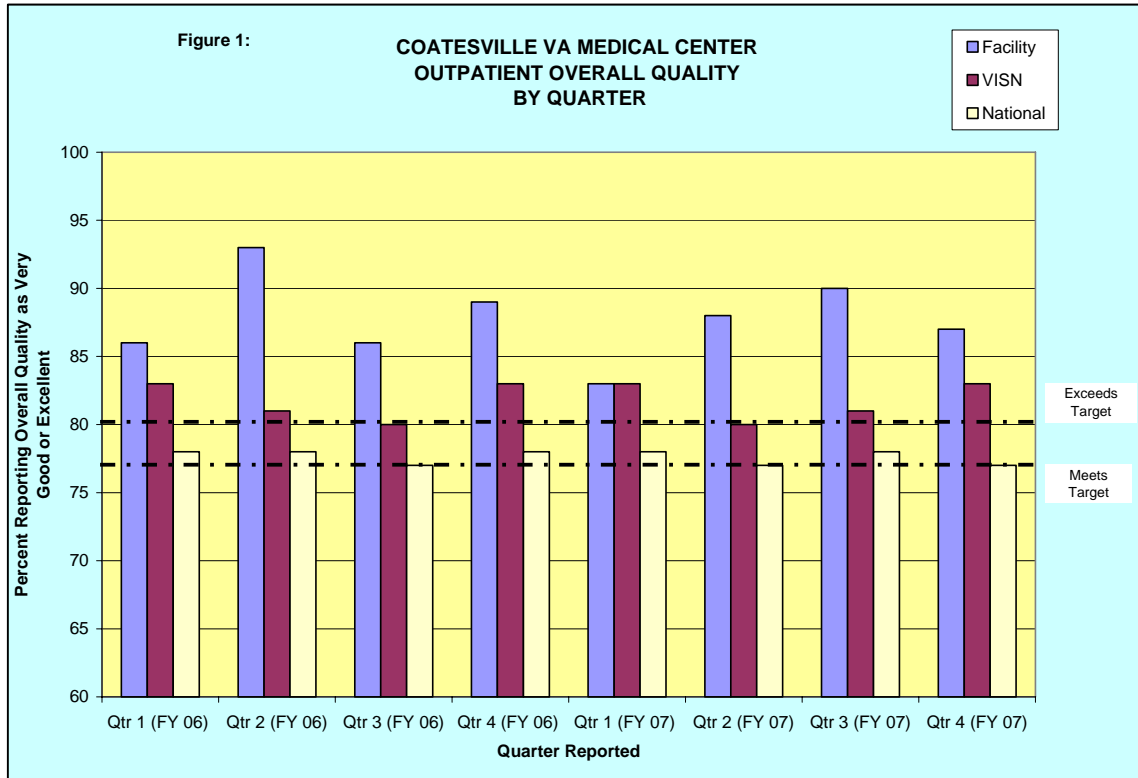
We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. We found that all of the business rules provided to the OIG inspector were in compliance with VHA Handbook 1907.1. The medical center has a multidisciplinary Health Information Team, which meets monthly to address issues raised during day-to-day operations and to discuss progress on implementation of OI informational patches.

We made no recommendations.

**Survey of
Healthcare
Experiences of
Patients**

The purpose of this review was to assess the extent that the medical center used the quarterly/semi-annual survey report results of patients' health care experiences to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients.

Figure 1 on the next page shows the medical center's SHEP performance measure results for outpatients.



The medical center met or exceeded the established target in all of the last 8 quarters of available data for outpatient overall quality. Because of the nature of the medical center’s inpatient population and the small number of medical inpatients, the SHEP response rate for inpatients does not meet statistically significant levels of measurement. However, the medical center still reviews the responses provided concerning inpatient care. The medical center also gathers patient satisfaction data through internal surveys. Analysis of the collected data is reported to the Customer Service Council, the Culture Change Committee, and the Director’s staff.

Through SHEP data and internal surveys, the medical center found that inpatient satisfaction for the length of time a patient waited for a response to a call button was lower than desired and closely related to technical problems with the dated system. After data analysis, a contract for a new nurse call system was proposed. The system was recently installed on the unit that was identified as having low scores.

In September 2007, internal surveys indicated that only 69 percent of patients on a particular inpatient unit rated the level of privacy in their rooms as “excellent” or “very good.”

Review of the data by staff resulted in a recommendation for a community forum to discuss privacy issues and educate patients and staff. Satisfaction scores for the next 3 months improved to 80, 90, and 88 percent, respectively. During this same interval, overall patient satisfaction scores rose from 70 to 100 percent positive.

We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 6, 2008

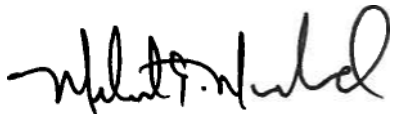
From: Network Director, VA Healthcare VISN 4 (10N4)

Subj: **Draft OIG CAP Report, VA Medical Center (Coatesville, PA)**

To: Margaret Seleski, Director, VHA Management Review Service (10B5)

1. I have reviewed the response to the draft OIG CAP report provided by the Coatesville medical center and concur with the response. I am submitting it to your office as requested.

2. If you have any questions or require additional information, please contact Barbara Forsha, VISN QMO, at 412-784-3871.



MICHAEL E. MORELAND, FACHE

Attachment

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 5, 2008

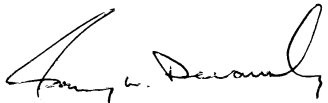
From: Director, Coatesville VA Medical Center (542/00)

Subject: **Combined Assessment Program Review of the
Coatesville VA Medical Center, Coatesville,
Pennsylvania**

To: Network Director (10N4)

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Coatesville VA Medical Center. We concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to our veterans.



Gary W. Devansky
Medical Center Director

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 Medical Center Director requires that monthly visits to CRC homes are documented in each CRC resident's electronic medical record.

Concur

Action Plan: A template progress note entitled "CRC Monthly Inspections" has been developed. This note will be used to document the Case Managers' monthly visits with the residents and CRC sponsors in the electronic medical record.

Target Date: Completed May 1, 2008.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the CRC Coordinator update the CRC handbook annually, meet with all CRC home operators annually to review the handbook, and document these meetings in the electronic medical record.

Concur

Action Plan: The CRC Coordinator will review and update the CRC handbook.

Target Date: May 15, 2008, and then annually in January of each year.

The CRC Coordinator will meet with all CRC facility operators to review the CRC handbook and document this meeting in the electronic medical record.

Target Date: July 31, 2008.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the CRC Coordinator meet annually with each VARO representative who acts as a fiduciary for a CRC resident to discuss the resident's finances and that this meeting is documented in the electronic medical record.

Concur

Action Plan: The CRC Coordinator and involved case managers will meet annually with VARO representatives of residents who receive VA funding. This discussion will be documented in the individual resident's electronic medical record.

Target Date: September 30, 2008.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC meet at least quarterly.

Concur

Action Plan: The peer review committee developed a schedule for quarterly meetings.

Target Date: Completed February 2008.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that annual training for controlled substances inspectors is conducted and documented.

Concur

Action Plan: Effective October 1, 2007, the Online Certification Training became our annual training requirement. As of 2/22/2008, all controlled substance inspectors completed the annual training. This process will continue.

Target Date: Completed February 22, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds and that documentation of participation is complete.

Concur

Action Plan: With the input from the OIG Inspector, a revised sign-in sheet was developed during the survey. The sign-in sheet has a section for a delegate if the assigned staff can not attend. Each discipline has submitted the name(s) of their qualified delegate to the leader of the EOC rounds.

Target Date: Completed April 11, 2008.

Recommendation 7. We recommended that the VISN Director ensure that Medical Center Director complies with VHA policy on security measures for protection of research animals.

Concur.

Action Plan: With input from the OIG Inspector, the animal research lab closed and locked the basement doors, and the contractor now enters from the front security door, signs in, and is monitored by research staff when working in the animal lab area.

Target Date: Completed April 11, 2008.

Recommendation 8. We recommended that the VISN Director ensure that Medical Center Director complies with VHA policy on patient safety standards for training of locked mental health unit staff and MSIT team participants and ensures that the MSIT team includes the appropriate disciplines.

Concur.

Action Plan: The psychiatric unit staff and MSIT team participants will complete the annual training which has been developed. The MSIT team will include all appropriate disciplines.

Target Date: May 30, 2008

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires appropriate staffing of the UCC during all hours of operation.

Concur

Action Plan: The Medical Center Director will assure that there is appropriate staffing of the Urgent Care Clinic during all hours of operation. This will be in accordance with VHA Directive 2007-043, Standards for Nomenclature and Operations for Urgent Care Clinics in VHA Facilities, and the Memorandum from the Deputy Under Secretary for Health for Operations and Management, Clarification of Provider Staffing Requirements for Emergency Departments and Urgent Care Clinics in VHA. There is physician coverage at the facility 7 days a week and 24 hours a day.

Target Date: Completed May 1, 2008.

OIG Contact and Staff Acknowledgments

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Contributors	Gail Bozzelli, RN Donna Giroux, RN, CPHQ Randall Snow, JD

Report Distribution

VA Distribution

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Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 4
Director, Coatesville VA Medical Center (542)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Joseph R. Biden, Jr.; Thomas R. Carper; Robert P. Casey, Jr.; Frank R. Lautenberg; Robert Menendez; Arlen Specter
U.S. House of Representatives: Robert E. Andrews, Robert Brady, Michael Castle, Charles W. Dent, Jim Gerlach, Tim Holden, Frank A. LoBiondo, Joseph R. Pitts, Jim Saxton

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