Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03175-09

Combined Assessment Program Review of the Northampton VA Medical Center Leeds, Massachusetts

October 16, 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 July 21–25, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Northampton VA Medical Center (the medical center), Leeds, MA. 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 for 41 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 assessed compliance with recommendations made during the September 2005 CAP review. We identified the following organizational strengths and reported accomplishments:

- Clinical managers improved patient and employee safety on the acute mental health (MH) unit.
- The medical center realized increased cost savings by improving its ability to transfer patients from non-VA inpatient care to VA inpatient care.

We made recommendations in five of the activities reviewed. For these activities, medical center managers needed to:

- Monitor hand hygiene compliance.
- Permanently repair the roof and ceiling over the food preparation area in the canteen kitchen.
- Test and maintain the WanderGuard® system.
- Ensure that medication and nutrition refrigerator logs include acceptable temperature ranges and maintenance contact information.
- Post suicide prevention information in patient care areas throughout the medical center.
- Inspect all emergency carts as required by local policy.
- Implement a peer review policy and ensure that the Peer Review Committee (PRC) fulfills all required functions.
- Implement a continuous performance monitoring plan for the medical staff and ensure that provider performance improvement (PI) data are analyzed as part of the reprivileging process.

- Monitor the effectiveness of all corrective actions.
- Establish benchmarks and monitor timeliness of radiology studies performed by fee basis agencies.
- Ensure that the urgent care clinic (UCC) provides written discharge instructions to patients.
- Ensure that the UCC complies with the Veterans Health Administration (VHA) directive for inter-facility transfers.
- Ensure that all registered nurses (RNs) who work in the UCC achieve the required clinical competencies annually.
- Ensure that the bar code medication administration (BCMA) policy defines a timeframe for documentation of pain medication effectiveness and monitor compliance.
- Ensure that interventions for patients having less than effective responses to pain medications are documented.
- Monitor compliance with BCMA documentation of pain scale assessments.
- Ensure that providers include discharge medications on all patient discharge summaries.

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

- Pharmacy Operations.
- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Katherine Owens, Director, Bedford 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 19–26 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 located in Leeds, MA, and provides inpatient and outpatient services. It also provides outpatient services at three community based outpatient clinics (CBOCs) in Greenfield, Pittsfield, and Springfield, MA. The medical center is part of VISN 1 and serves a veteran population of about 85,000 in western Massachusetts.

Programs. The medical center provides primary care services, inpatient and outpatient MH services, inpatient post-traumatic stress disorder (PTSD) treatment, and long-term care services. Additionally, it offers an extensive network of residential care settings, and the Springfield CBOC offers home-based primary care services. The medical center also has a comprehensive homeless program.

Affiliations and Research. The medical center is not affiliated with a medical or dental school but is a training site for nursing, social work, pharmacy, and other professional and technical health care programs. It conducts no research.

Resources. In FY 2007, the medical care budget totaled more than $76.5 million. Total FY 2008 staffing is 562 full-time employee equivalents (FTE), including 38 physician and 131 nursing FTE.

Workload. During FY 2007, the medical center treated more than 13,900 unique patients and provided inpatient treatment to over 1,200 patients. It had 85 operating hospital beds with an average daily census (ADC) of 72 and 66 community living center (CLC)[1] beds with an ADC of 58. FY 2007 outpatient workload totaled more than 157,000 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:

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- 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:

- Coordination of Care.
- Emergency Department/UCC (ED/UCC).
- Environment of Care (EOC).
- Medication Management.
- Pharmacy Operations.
- QM Program.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and quarters 1 and 2 of FY 2008 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, Massachusetts,* Report No. 05-01606-134, April 27, 2006). In that report, we identified improvement opportunities for EOC and radiology timeliness. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address most of the recommendations, and with the exception of the two areas that follow, we consider those issues closed. We determined that the recommendations for

emergency cart inspections and monitoring the timeliness of fee basis radiology studies had not been completely addressed. Therefore, we reissued recommendations for these areas.

During this review, we presented fraud and integrity awareness briefings for 41 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 made 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 Strengths

Patient and Employee Safety

The medical center improved patient and employee safety on the acute MH unit by modifying the admission process. Patient search procedures for contraband performed on the unit at the time of admission proved ineffective. Consequently, the MH unit recorded six incidents of contraband for August–December 2007, which posed a potential threat to patients and employees.

As a result of a root cause analysis (RCA), admission procedures were changed. Prior to being escorted to the MH unit, patients now change into pajamas (required for the first 24 hours after admission). All items brought to the medical center by patients are taken to the patient effects area where they are inventoried and searched. At the time of our visit, there had been no additional incidents of contraband on the MH unit since the implementation of the new process.

Patient Transfers

The medical center improved its ability to transfer patients from non-VA inpatient care to VA inpatient care. In FY 2007, the medical center arranged transfers for approximately 20 percent of the patients receiving inpatient care in non-VA facilities. During the first 3 quarters of FY 2008, the medical center increased its transfer rate to 31 percent.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA regulations require that health care facilities establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards. We inspected the following areas: (a) two long-term care units, (b) the inpatient PTSD unit, (c) the UCC, (d) the inpatient and outpatient pharmacies, (e) acute MH, (f) the dental clinic, (g) primary care, and (h) the Springfield CBOC.

The areas we inspected were generally clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their units. However, we identified the following issues that needed improvement.

Infection Control. While infection control (IC) personnel monitored hand hygiene compliance beginning in June 2008, we were provided no documentation to support that IC managers had previously monitored hand hygiene compliance, as required by VHA regulations[2] and medical center policy.[3] Additionally, we found a large hole and a leak in the ceiling of the canteen kitchen over the food preparation area, which posed an IC risk. VHA regulations[4] require that facilities maintain safe and sanitary conditions in all areas of the canteen.

Safety. We reviewed polices and procedures for the WanderGuard®[5] system used in the CLC and in the long-term MH unit. We found that Facility Management Service (FMS) managers could not provide documentation that they performed monthly system maintenance tests, as required by medical center policy.[6]

Additionally, we reviewed the acute inpatient MH unit to determine whether managers identified environmental hazards that potentially posed threats to patients and to

[2] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.
[3] Medical Center Memorandum 009-26, *Exposure Control Plan, Attachment B,* October 2005.
[4] VHA Manual M-1, Part IV, *Veterans Canteen Service*, January 13, 1992, Chap. 1.
[5] WanderGuard® is an electronic elopement management system.
[6] Medical Center Memorandum 009-06, *Management of the Wanderguard® System,* July 2006.

ensure that staff received specialized training. The medical center provided documentation of risk assessment and abatement tracking of safety issues previously identified on the MH unit, and we found that suicide risk training was completed. However, we found that temperatures logs for medication and nutrition refrigerators located on the MH unit lacked information pertinent to acceptable temperature ranges and didn't provide contact information in the event of a malfunction.

Suicide Prevention Information. We found that suicide prevention information was not available in all patient care areas throughout the medical center, as required by the memorandum to VISN Directors and Medical Center Directors from the Deputy Under Secretary for Health for Operations and Management.[7]

Emergency Carts. We followed up on a recommendation made in our prior CAP report. In that report, we recommended that emergency carts[8] be inspected in accordance with medical center policy.[9] While we found that managers performed monthly audits to ensure that inspections were completed, inspection logs for the two crash carts located on the inpatient PTSD unit indicated that the required daily inspections were not completed for 2 days in July 2008. The inspection log on the long-term MH unit showed that the emergency cart located on the unit had not been inspected for 1 day in July 2008. Since desired results for this recommendation were not fully achieved, we reissued a recommendation in this area.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that IC personnel monitor hand hygiene compliance and initiate corrective actions when monitors fall below established thresholds.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that IC personnel established a hand hygiene monitor and updated the policy to reflect improved data collection methodology and reporting. The implementation plans are acceptable,

[7] Deputy Under Secretary for Health for Operations and Management, "Suicide Prevention Awareness Materials," memorandum to Network Directors and Medical Center Directors, December 7, 2007.
[8] Emergency carts are portable carts located in patient care areas that contain emergency equipment, supplies, and medications used to stabilize a person who experiences a cardiopulmonary emergency.
[9] Medical Center Memorandum, 006-01, *Medical Emergency Carts and Equipment: Guidelines for the Storage, Use, and Maintenance, Attachment 1*, May 2007.

and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the ceiling and roof over the food preparation area in the canteen kitchen be permanently repaired.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the roof will be replaced after acceptance of the final bid. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that FMS managers test and maintain the WanderGuard® system and retain documentation of maintenance.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that Nursing Service tests the integrity of the system daily and that FMS managers will maintain a repair history. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that medication and patient nutrition refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the medication and patient nutrition refrigerator logs will reflect temperature ranges and maintenance contact information. The revised logs will be distributed to all units by October 1, 2008. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that suicide prevention materials be posted in patient care areas throughout the medical center.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the Suicide

Prevention Coordinator and service line managers will ensure that suicide prevention information is available in patient care areas and that the Environmental Rounds Team has added this item to its monitoring list. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that all emergency carts be inspected in accordance with medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that monthly audits of crash cart logs have been established and that the results will be reported to the Quality Council quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified issues that needed improvement.

Peer Review. In 2004, VHA regulations[10] required that VA health care facilities develop and implement facility-level peer review policies and establish PRCs. VHA reinforced these requirements in its directive published in January 2008.[11] At the time of our review, senior clinical managers were in the process of updating the medical center's policy[12] governing the peer review process to conform to VHA regulations. Also, they had recently established a PRC, which had met once. Managers needed to implement a peer review policy that meets VHA

[10] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[11] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[12] Medical Center Memorandum 11-22, *Peer Review Process*, September 24, 2002.

requirements and ensure that the PRC performs all the functions required by VHA policy.

Provider Performance Monitoring. VHA regulations[13] and The JC require that clinical managers collect and review provider performance data as part of the reprivileging process.[14] According to the requirements, performance data should be ongoing, include indicators for continuing qualifications and competencies, and be reviewed and considered during the reprivileging process. Clinical leaders completed the training sessions for credentialing and privileging (C&P); however, at the time of our review, they had not yet developed plans for continuous evaluation of performance data. Additionally, we reviewed C&P folders for nine providers reprivileged in the past 12 months. None of the nine providers had adequate performance data.

Effectiveness Monitoring. While the medical center monitored the effectiveness of corrective actions generated by RCAs, the process to monitor corrective actions identified outside of the RCA process was not clearly defined. A review of committee minutes and other documentation showed that issues identified multiple times by committees continued to have the same corrective actions documented (for example, memorandums sent to service line managers or issues referred to nurse managers). This indicated that the actions were ineffective and that managers needed to analyze issues in more depth.

Radiology Timeliness. As part of the QM Program assessment, we followed up on radiology recommendations made in our prior CAP report. In that report, we recommended that processes be developed to monitor radiology studies performed by fee basis providers to ensure that they are completed and that the results are reported timely to providers. We found that managers collected raw data showing when fee basis radiology studies were performed and when the reports were returned to the facility. However, no timeliness benchmarks were established (either from VHA guidelines or by the medical center), and managers did not analyze the data in a way that identified trends. Since desired results for this recommendation were

[13] VHA Handbook 1100.19, *Credentialing and Privileging,* October 2, 2007.
[14] The process of evaluating professional credentials and clinical competencies of practitioners who hold clinical privileges at the facility.

not fully achieved, we reissued a recommendation for this area.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers implement a peer review policy and ensure that the PRC fulfills all required functions.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that managers published a peer review policy. They also reported that all PRC members have received the required training and that other professional staff will complete required training by September 30, 2008. The PRC will meet at least quarterly and report peer review data to the Executive Committee of the Medical Staff (ECMS) quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that a continuous performance monitoring plan be implemented and that provider PI data be collected and analyzed as part of the reprivileging process for all providers.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that each service line manager will develop specific performance criteria for continuous monitoring by November 1, 2008, and that the Professional Standards Board will incorporate the results of performance analysis into the reprivileging process. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that managers monitor the effectiveness of all corrective actions and modify actions when they prove to be ineffective.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that QM managers will monitor major committee minutes to ensure that corrective actions are measurable and that improvement actions are modified when they prove to be ineffective. The

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that radiology managers establish benchmarks to monitor the timeliness of radiology studies performed by fee basis agencies and analyze data to identify trends.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that radiology managers will analyze timeliness data and will report trend analyses monthly to the ECMS. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Department/Urgent Care Clinic

The purpose of this review was to evaluate selected aspects of patient care and operations in VHA ED/UCCs, such as clinical services, consults, transfers, discharges, staffing, and staff competencies. We also determined whether the physical environment was clean and safe and whether managers maintained equipment appropriately. The medical center did not have an ED but did have a UCC that was open 7 days a week, 24 hours a day. Administratively, the UCC came under the jurisdiction of the Primary Care and Specialty/Acute Care Service Line.

We interviewed the UCC's nurse manager and medical director and the transfer coordinators. We reviewed policies and other pertinent documents, including equipment maintenance records. Additionally, we reviewed medical records of patients who had consults to other medical or rehabilitation services, who were discharged from the UCC, and who were transferred from the UCC to other medical facilities. Our review showed that consults and staffing were appropriate. We conducted an EOC tour and found that the area was clean and safe and that managers appropriately maintained equipment. However, we identified issues that needed improvement.

Written Discharge Instructions. The JC requires that written discharge instructions be provided to patients when they are discharged from an ambulatory care area.[15] We reviewed the medical records of two patients who were discharged from the UCC and found no documentation to support that

[15] The JC, *Comprehensive Accreditation Manual for Ambulatory Care,* January 2007, p. PC-26.

they received written discharge instructions. We found that this was inconsistent with other areas of the medical center where documentation showed that written discharge instructions were provided to patients.

Inter-Facility Transfer. We reviewed the medical records of three patients who were transferred from the UCC to other medical facilities. Transfer documentation did not comply with VHA regulations[16] that mandate the use of VA Form (VAF) 10-2649A "Inter-Facility Transfer Form" and VAF 10-2649B "Physician Certification and Patient Consent for Transfer." We found that this was inconsistent with other areas of the medical center where the mandated forms were used at the time of transfer.

Competencies. We reviewed the competency folders and training summaries of five RNs who worked in the UCC during administrative and non-administrative hours, and we interviewed nurse leaders. Both VHA and The JC require that nursing staff assignments be congruent with patient care needs and employee qualifications.[17] The medical center required that the following competencies be achieved by UCC RNs annually: (a) advanced triage and assessment skills; (b) Advanced Cardiac Life Support (ACLS); (c) restraints and seclusion; and (d) point-of-care testing, including glucose (blood sugar) levels and breathalyzer[18] testing. Interviews and our review of the folders revealed that:

- All five RNs had current competencies for glucose testing.
- None of the five RNs had current competencies for breathalyzer testing or restraints and seclusion.
- Four of the five RNs who covered the UCC during evenings, nights, weekends, and holidays did not have competencies for advanced triage and assessment skills or ACLS.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that the UCC provide written discharge instructions to patients.

[16] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[17] VHA Manual M-2, Part V, *Clinical Affairs, Nursing Service,* July 13, 1989; The JC, p. HR9-10.
[18] The breathalyzer is a device that measures the alcohol content of an individual's breath and estimates the alcohol level of the blood.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that a template for UCC discharge instructions will be developed and implemented by November 1, 2008. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that the UCC comply with VHA policy governing inter-facility transfers.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the Urgent Care Team will develop a process to ensure completion of required inter-facility patient transfer documentation. The new process will be implemented by September 30, 2008. They also reported that current medical center policies that reference patient transfers will be consolidated by November 30, 2008, to ensure continuity of care. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires that all RNs who work in the UCC during administrative and non-administrative hours achieve the required clinical competencies annually.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that Nursing Service and the UCC manager will identify core clinical competencies required for all RNs who work in the UCC and develop a competency assessment. This assessment will be completed by November 30, 2008, and then annually. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management processes that ensured safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes in the CLC and the acute MH unit, and we interviewed the units' nurse managers, nursing staff, and pharmacy managers.

We found adequate management of medications brought into the facility by patients or their families. Pharmacists

reviewed all medication orders, and qualified pharmacists were available by phone when the pharmacies were closed. We observed appropriate use of BCMA to correctly identify patients prior to medication administration, and we found that reconciliation of controlled substances (CS) discrepancies at the unit level was adequate. However, we identified issues that needed improvement.

Pain Medication Effectiveness. VHA regulations[19] and medical center policy[20] require that the effects of pain medications be monitored. We reviewed 15 administered doses of PRN[21] pain medication and found that the times between medication administration and the times that the patients' responses to the medication were documented ranged from 4 minutes to 542 minutes. We also found that the medical center's BCMA policy[22] did not define an appropriate timeframe for PRN effectiveness documentation. Additionally, we found that for 3 of the 15 doses, less than effective patient responses were documented, and additional interventions were required. We did not find documentation of additional interventions for two of the three doses.

Pain Scale Score Documentation. BCMA has an option that allows nurses to document pain scale score assessments[23] in BCMA at the time a patient receives pain medication. At the time of our review, that option was inactive, requiring nurses to document pain assessments in the computerized patient record system. This was an additional step and could lead to this information not being documented. The BCMA option was activated while we were onsite.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that the BCMA policy define a timeframe for PRN pain medication effectiveness documentation and that nurse managers monitor compliance.

The VISN and Medical Center Directors agreed with the findings and recommendation. Managers will modify the policy and define a timeframe for documentation of PRN effectiveness. Nursing Service will monitor compliance and

[19] VHA Directive 2003-021, *Pain Management*, May 2, 2003.
[20] Medical Center Memorandum 11-15, *Pain Management Policy*, December 13, 2005.
[21] PRN is a Latin abbreviation [L *pro re nata]* meaning as needed or as the circumstances require.
[22] Medical Center Memorandum 001-26, *Bar Code Medication Administration (BCMA)*, November 29, 2006.
[23] Pain scale scores are used to measure patients' pain intensity. The pain scale ranges from 1 (no pain) to 10 (worst possible pain).

report to the Quality Council quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director requires that interventions to improve patients' responses to pain medication are documented.

The VISN and Medical Center Directors agreed with the findings and recommendation. They reported that nurses will document responses to pain medication, and nurse managers will monitor compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 16 We recommended that the VISN Director ensure that the Medical Center Director requires nurse managers to monitor compliance with pain scale assessment documentation in BCMA.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that nurse managers will monitor compliance with pain scale documentation and report on a quarterly basis to the Quality Council beginning with the October 20, 2008, meeting. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether VHA facilities had adequate processes to ensure coordination of care across the continuum of patient care services. For this evaluation, we reviewed four aspects of care on the CLC and the acute MH unit: (a) patient consults, (b) patient intra-facility transfers, (c) patient inter-facility transfers, and (d) patient discharges.

We found that providers managed patient consults and intra- and inter-facility transfers from the inpatient units appropriately. However, we found that in two of six medical records reviewed, discharge medications were not listed on the discharge summaries. VHA regulations[24] require that discharge medications be listed on discharge summaries.

[24] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendation 17 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge medications be listed on all discharge summaries.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that managers formed a Medication Reconciliation Team to develop a process to ensure that discharge medications are listed on discharge summaries. The team will monitor compliance beginning November 30, 2008. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Pharmacy Operations

The purposes of this review were to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments and whether clinical managers had processes to monitor inpatient and outpatient medication use to avoid polypharmacy in vulnerable populations, such as the elderly and mental health patients.

Pharmacy Controls. We reviewed VHA regulations[25] governing pharmacy and CS security, and we assessed whether the medical center's policies and processes were consistent with VHA regulations. In addition, we interviewed the CS inspection coordinator and appropriate Pharmacy Service managers. We found pharmacy controls to be appropriate and the environments to be secure and clean.

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

[25] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

treat adverse drug reactions.[26] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[27]

We interviewed pharmacy clinical managers to determine the medical center's efforts to monitor and avoid inappropriate polypharmacy. Clinical pharmacists identified patients who were prescribed multiple medications, reviewed the patients' medication regimens to avoid complications related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive nurse staffing guidelines and whether nursing leaders followed the guidelines. We reviewed nurse staffing documents for the CLC and the acute psychiatry units, and we interviewed nurse managers. We found the nurse staffing methodology to be appropriate. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities used quarterly or semi-annual SHEP results to improve patient care 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 goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

We reviewed survey results for quarters 2–4 of FY 2007 and quarter 1 of FY 2008. The medical center's inpatient scores met or exceeded VHA's target goals in 3 of 4 quarters reviewed. The medical center's outpatient scores exceeded VHA's target goals for all 4 quarters reviewed. The results are displayed in the graphs on the next page.

[26] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[27] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

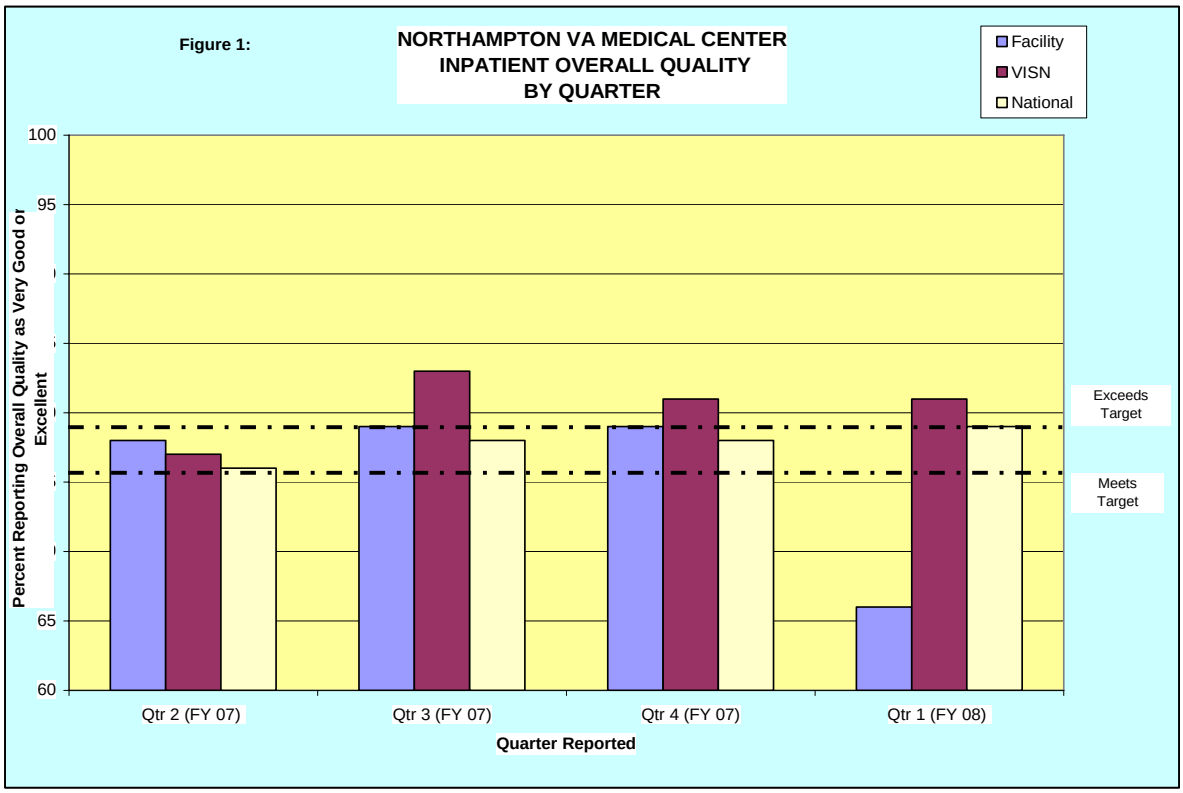
Figure 1:
NORTHAMPTON VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
100
95
65
60
Percent Reporting Overall Quality as Very Good or
Excellent
Exceeds
Target
Meets
Target
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Quarter Reported

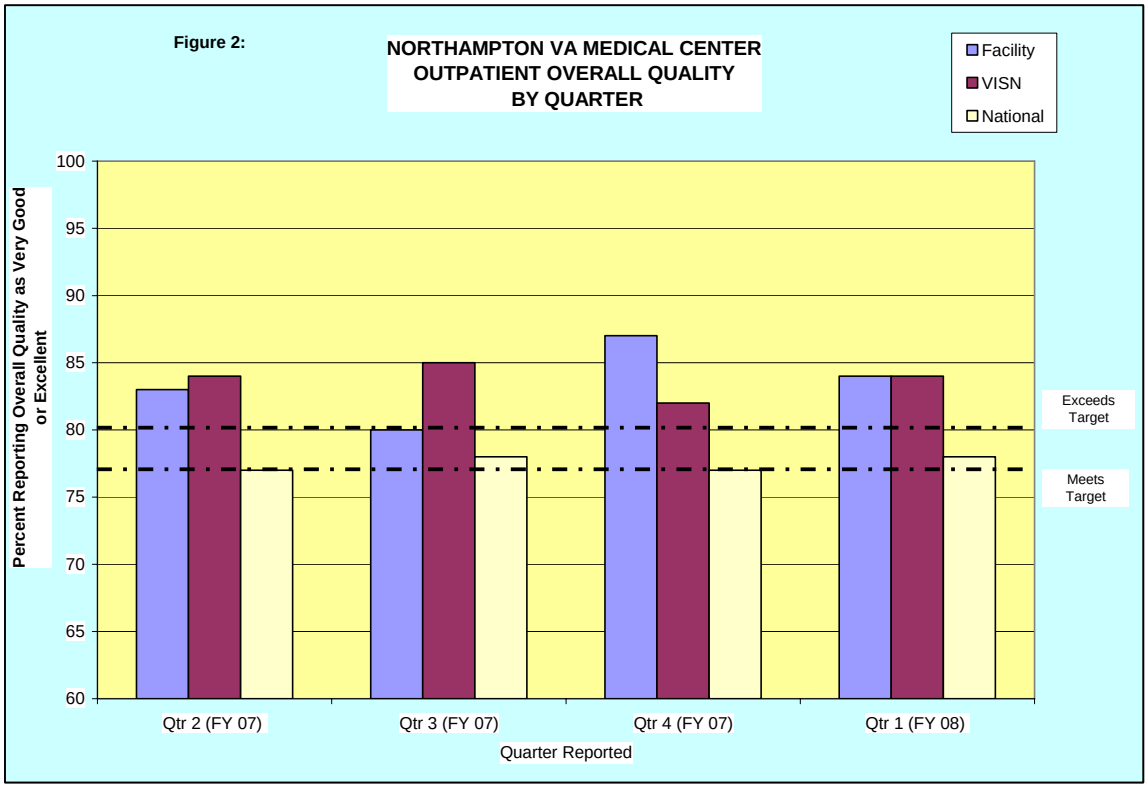
Figure 2:
NORTHAMPTON VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
100
95
90
85
80
75
70
65
60
Percent Reporting Overall Quality as Very Good
or Excellent
Exceeds
Target
Meets
Target
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Quarter Reported

Medical center managers analyzed their survey results, developed improvement strategies, and monitored the results of the action plans. Survey results and improvement strategies were disseminated throughout the organization. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 27, 2008

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

Subject: **Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, Massachusetts**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

I have reviewed the findings and Recommendations and concur. Our actions to the Recommendations are attached.

(original signed by:)

MICHAEL F. MAYO-SMITH

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 27, 2008

From: Director, Northampton VA Medical Center (631/00)

Subject: **Combined Assessment Program Review of the Northampton VA Medical Center, Leeds, Massachusetts**

To: Director Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the Northampton VA Medical Center conducted on July 21–25, 2008.

We concur with the recommendations and have already initiated corrective actions.

If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (413) 582-3000.

(original signed by:)

MARY A. DOWLING

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 IC personnel monitor hand hygiene compliance and initiate corrective actions when monitors fall below established thresholds.

Concur

Monitor established in May 2008 by the Infection Control Nurse. The governing policy has been updated to change methodology of data collection and reporting. Reporting will be through the Infection Control Committee to the Executive Committee of the Medical Staff (ECMS) on a quarterly basis. This began with the August 19, 2008, meeting. Infection Control Committee will monitor and forward any actions to the ECMS. ***We request this recommendation be closed.***

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the ceiling and roof over the food preparation area in the canteen kitchen be permanently repaired.

Concur

An engineering review has determined that a replacement of the roof (vs. localized repairs) is the best approach to resolving problems with water leakage. Ventilation equipment on the roof also exacerbates this problem. The plan is to redesign and consolidate the ventilation to minimize its impact on the integrity of the roof. This will require a detailed redesign package targeted for completion by September 5, 2008. Estimated time from package design to roof replacement is four (4) months after Acquisitions accepts the final bid (process estimated to be three (3) months). Estimated cost is $100K.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that FMS managers test and maintain the Wanderguard® system and retain documentation of maintenance.

Concur

Current policy requires nursing to test the integrity of the system on a daily basis and this is documented. It also requires that Facilities test the system monthly for maintenance. As the system is a solid state electronic system and Facilities does not have the working knowledge of repair, the policy has been amended to state "*Should the system fail at any time, Facilities Management is responsible for working with the manufacturer to replace all or part of the system for the most expeditious return to full working order."* A repair history of the system will be maintained by Facilities Management. **We request this recommendation be closed.**

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that medication and patient nutrition refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance.

Concur

The log will be revised to include all required elements for both nutrition and medication refrigeration units and will be distributed to all units. Staff will be notified of change in forms and this will be implemented by October 1st, 2009. AO Nursing Service in conjunction with Quality Management will monitor implementation of this process and take actions as necessary.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that suicide prevention materials be posted in patient care areas throughout the medical center.

Concur

The facility Suicide Prevention Coordinator (SPC) will contact all facility Service Lines on a monthly basis to ensure stocks of Suicide Information are readily available to patients and families. Additionally, the weekly Environmental Rounds Team has added this topic to the monitoring list. This will be implemented by immediately. **We request this recommendation be closed.**

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all emergency carts be inspected in accordance with medical center policy.

Concur

Monthly audits of crash carts logs have been implemented immediately to ensure that emergency carts throughout the Medical Center are inspected in accordance with Medical Center Policy. Data collection will begin retrospectively beginning with review of the July logs. Designated staff members have been assigned to complete these audits and submit data

to Quality Management monthly. Appropriate actions will be developed based on findings and monitored by respective service lines. Results of audits and actions will be reported quarterly to Quality Council. **We request this recommendation be closed.**

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers implement a peer review policy and ensure that the PRC fulfills all required functions.

Concur

The Peer Review policy has been published. The Peer Review Committee was formally established in June 2008. Required training has been accomplished by all members. Required training for other professional staff is targeted to be completed by September 30, 2008. The Peer Review Committee will meet at least quarterly and report peer review data to the Executive Committee of the Medical Staff (ECMS) quarterly.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that a continuous performance monitoring plan for the medical staff be implemented and that provider PI data be collected and analyzed as part of the reprivileging process for all providers.

Concur

Each Service Line Manager (SLM) to develop specific criteria for continuous monitoring by November 1, 2008. Criteria will be reviewed by both the Professional Standards Board and ECMS by November 1, 2008. Performance Improvement data will be analyzed and reviewed by the Professional Standards Board as a part of the reprivileging process.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that managers monitor the effectiveness of all corrective actions and modify actions when they prove to be ineffective.

Concur

Quality Management (QM) to develop a class on minute taking and present on September 3, 2008. QM will monitor major committee minutes to ensure that corrective actions are well articulated and measurable; and ineffective actions are modified and follow through is accomplished. Progress will be reported to the Quality Council on a monthly basis beginning with the September 22, 2008, meeting.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that radiology managers establish benchmarks to monitor radiology studies performed by fee basis agencies and analyze data to identify trends.

Concur

Crude data has been collected, but not displayed and analyzed. Benchmarks will be established and data will be transformed into graphic display and presented by Chief, Pathology & Laboratory Medicine quarterly at ECMS with trend analyses, beginning with the October 21, 2008, ECMS meeting.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that the UCC provide written discharge instructions to patients.

Concur

CPRS template for UCC discharge instructions to be developed; staff training will immediately follow template development and will be completed by October 30, 2008. Discharge instructions for UCC patients will be utilized beginning November 1st, 2008.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that the UCC comply with the VHA policy governing inter-facility transfers.

Concur

Urgent Care Team to develop process to ensure completion of required transfer documentation (September 30, 2008). Utilization of the required forms will ensure that all the documentation elements will be addressed. Additionally, policies referencing transfers will be consolidated to ensure continuity (November 30, 2008). The Firm Manager, in conjunction with Quality Management, will monitor for compliance and take necessary action(s).

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires that all RNs who work in the UCC during administrative and non-administrative hours achieve the required clinical competencies annually.

Concur

Nursing Service and UC manager to jointly identify core clinical competencies required for all RN's who work in UCC during both administrative and non-administrative hours and develop competency

assessment. This assessment will be completed by supervisors by November 30th and annually thereafter. The supervisor will develop an educational plan to ensure successful achievement of required clinical competencies. Primary Care Firm Manager in conjunction with Nursing Service will monitor for continuity and take actions as needed.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that the BCMA policy define a timeframe for PRN pain medication effectiveness documentation and that nurse managers monitor compliance.

Concur

Policy will be modified to include a specific timeframe (September 2, 2008). Documentation will be made within two (2) hours of administration. Nursing Service will develop monitor to be reported to Quality Council on a quarterly basis, beginning with the October 20, 2008, meeting.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director requires that interventions to improve patients' responses to pain medication are documented.

Concur

Staff will comply with the pain management policy in assessing, implementing pain management plan as appropriate and documenting the responses interventions. Nurse Managers will monitor and report on a quarterly basis to Quality Council, beginning with the October 20, 2008, meeting.

Recommendation 16. We recommended that the VISN Director ensure that the Medical Center Director requires nurse managers to monitor compliance with pain scale assessment documentation in BCMA.

Concur

BCMA pain scale functionality was activated prior to OIG exit and is working properly. In conjunction with recommendation 15, nurse managers will monitor compliance with pain scale documentation and report on a quarterly basis to Quality Council, beginning with the October 20, 2008, meeting. **We request this recommendation be closed.**

Recommendation 17. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge medications be listed on all discharge summaries.

Concur

A Medication Reconciliation team has been appointed to review the process and develop strategies to ensure that discharge medications are listed in the discharge summary. The Medication Reconciliation team will monitor for compliance with the process and take action(s) as needed. Target date November 30, 2008.

OIG Contact and Staff Acknowledgments

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