



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

Office of Healthcare Inspections

Report No. 07-02498-52

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



January 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 September 17–21, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Philadelphia VA Medical Center (the medical center). 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 176 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. We made recommendations in all of the activities reviewed. For these activities, the medical center needed to:

- Ensure that data analyses are reported to the appropriate committees and that specified corrective actions are documented, implemented, and monitored.
- Improve peer review process timeliness and participant training.
- Require tracking and trending of patient complaint data.
- Improve processing times for root cause analyses (RCAs).
- Require completion of staff education on the handoff communication policy.
- Enhance review of admission and continued stay cases that do not meet medical center criteria.
- Require the Patient Flow Committee to meet regularly to continue implementation and evaluation of action plans.
- Conduct community based outpatient clinic (CBOC) environment of care (EOC) rounds semi-annually, require participation of all designated EOC team members in all EOC rounds, and ensure that documentation of EOC rounds and attendance is complete.
- Issue staff on the 7-East Acute Psychiatric Unit keys to locked fire extinguishers and provide 7-East staff with training on Veterans Health Administration (VHA) Directive 2005-037, *Planning for Fire Response*, and Medical Center Memorandum No. 138-05, *Fire Plan*.

- Develop and implement an action plan for improvement of patient care based on internal surveys and Survey of Healthcare Experiences of Patients (SHEP) data results, with service line and executive-level involvement.
- Comply with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 VHA Office of Information (OI) guidance.
- Establish consistency in medical record documentation through the use of computerized patient record system (CPRS) templates developed specifically for patients receiving post-anesthesia care.

This report was prepared under the direction of Randall Snow, J.D., Associate Director, Washington, D.C., 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 16–21, 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 tertiary care facility located in Philadelphia, PA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs in Sewell and Fort Dix, NJ, and in Philadelphia and Horsham, PA. The medical center is part of VISN 4 and serves a veteran population of about 400,000 in America's fifth largest metropolitan area and seven surrounding counties in Pennsylvania, New Jersey, and Delaware.

Programs. The medical center provides primary care, acute care, and long-term care services. It has 135 hospital beds and 220 nursing home beds.

Affiliations and Research. The medical center is affiliated with the University of Pennsylvania's School of Medicine and School of Dental Medicine and provides training for more than 100 residents, as well as other disciplines, including nursing and dentistry. In fiscal year (FY) 2006, the medical center research program had 278 projects and a budget of \$29 million. Important areas of research include health services and outcomes, with emphasis on equitable access to health care; infectious diseases, including hepatitis C and human immunodeficiency virus; and neurodegenerative disorders, including Parkinson's disease, Alzheimer's disease, and traumatic brain injury.

Resources. In FY 2006, medical care expenditures totaled \$312 million. The FY 2007 medical care budget was \$319 million. FY 2006 staffing was 1,729 full-time employee equivalents (FTE), including 139 physician and 350.2 nursing FTE.

Workload. In FY 2006, the medical center treated 57,339 unique patients and provided 41,482 inpatient days in the hospital and 75,971 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 5,337 discharges, and the average daily census, including nursing home patients, was 321.7. Outpatient workload totaled 431,609 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 five activities:

- CPRS Business Rules.
- EOC.
- Patient Satisfaction.
- QM.
- Surgical Care Improvement Project.

The review covered medical center operations for FYs 2005, 2006, and 2007 through September 21, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Philadelphia VA Medical Center, Philadelphia, Pennsylvania*, Report No. 04-01130-109, March 23, 2005). The medical center had corrected all health care related conditions identified during our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 176 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.

Results

Review Activities With Recommendations

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, Chief of Staff, Chief Nurse Executive, 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 areas that needed improvement.

Action Plans. We found that staff analyzed data in all program areas reviewed. However, we did not find evidence of corrective action plans to address identified problems in multiple areas, including executive leadership, patient complaints, utilization management, and Quality Council. Medical center managers need to decide how the data analyses will be reported and to ensure that specific corrective actions are documented and implemented when problems are identified.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. 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 care¹ with

¹ 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.

subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings.

Education. All individuals involved in the peer review process are required to receive formal education regarding the peer review process, their responsibilities, and the medical center's legal and ethical requirements. Clinical staff members of the Medical Executive Board function as the PRC, and all clinical staff at the medical center may serve as peer reviewers. There was no formal documentation that the providers involved in peer review had received peer review education.

Timeliness. Initial peer reviews must be completed within 45 days from the date of determination that a peer review is necessary. Of the 76 peer reviews initiated since September 2006, 7 were not completed within this timeframe. One peer review required 1 year to complete. Final evaluations by the PRC should be completed within 120 days from the date of determination that a peer review is necessary. Fifteen of the 76 peer reviews evaluated were not completed within the 120 days.

Action Plans. Recommendations resulting from peer review discussions should be documented, and action items that result from these recommendations should be documented and tracked. Although PRC discussions were well documented, the action plans were not documented or tracked.

Patient Complaints. VHA Handbook 1003.4, *VHA Patient Advocacy Program*, requires that patient complaint and patient satisfaction data are collected, trended, analyzed, and reported to the appropriate facility committees and forums. The Customer Service Committee last met in February 2006. Five out of the 14 committee members were present. Data on patient complaints and patient satisfaction were not analyzed to identify significant trends.

Root Cause Analysis. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires completion of an RCA within 45 days of identification of a sentinel event.² We reviewed seven individual RCAs; none were

² A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

completed within 45 days. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could not be assured of a comprehensive and efficient patient safety process.

National Patient Safety Goals for 2007. VHA requires that all facilities comply with Joint Commission³ National Patient Safety Goals. Compliance with the goal of improving the effectiveness of communication among caregivers needs improvement.⁴ In a recent assessment of handoff communication between caregivers, the medical center met this goal only 50 percent of the time. In addition, during the past year, there have been two serious incidents reported that involved handoff communication between caregivers during inter-unit patient transfers. A process action team on handoff communication met from June 26, 2006, through November 29, 2006. In September 2007, the committee completed a handoff communication policy and initiated staff education.

Utilization Review. Utilization review is the evaluation of how certain medical services are requested and performed. The review typically involves pre-authorization, evaluation of inpatient care and needs, and the larger historical picture of how physicians, laboratories, or hospitals handle their patient populations. Admission and continued stay analyses were performed, but no specific actions were documented when the reviewed cases did not meet criteria. For example, during the 3rd quarter of FY 2007, only 61 percent of cases reviewed met the continued stay criteria, yet no specific problems were identified, and no action plans were documented.

Patient Flow. Joint Commission standards require medical center management to assess patient flow issues within the medical center, to assess the impact on patient safety, and to implement plans to mitigate the impact of those issues.⁵ Medical center staff, along with an outside consultant, conducted a patient flow assessment from January through May 2007. This assessment was presented to medical center leadership, who identified goals and formulated action

³ The Joint Commission was formerly the “Joint Commission on Accreditation of Healthcare Organizations,” also known as JCAHO.

⁴ National Patient Safety Goal 2: Improve the effectiveness of communication among caregivers. Goal 2E: Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.

⁵ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Standard LD.3.15.1.

plans. The medical center initiated several of the action plans and continues to monitor them. However, from May through August 2007, the Patient Flow Committee did not formally meet to continue the implementation and evaluation of action plans. During our inspection, we identified the following patient flow problems.

Patient Parking. The patient parking garage has 280 parking spots. On an average day, the medical center treats 1,500 outpatients and 111 inpatients. Between January and March 2007, 5,420 patients did not show up for scheduled primary care appointments. In order to identify the reasons for the high rate of missed appointments, the medical center sent a survey to those patients who missed these appointments, and 2,119 responded. Thirty-one percent (703) of patients responding stated that lack of patient parking was the main reason they missed their appointments.

The patient parking garage is configured with a dead end at the bottom of the entry ramp. The size of the parking garage coupled with the demand for parking and the traffic configuration forces drivers to make a U-turn to exit the garage. At peak traffic times, several drivers at once make U-turns while pedestrians try to walk around and through the traffic, creating a patient safety hazard. Patients who cannot find parking are routinely late for appointments or give up and go home.

Nursing Home Care Units. NHCU patients are not timely discharged when they no longer meet the requirements for nursing home care. VHA Directive 2006-014, *Admission Criteria, Service Codes, and Discharge Criteria for VA Nursing Home Care Units (NHCU)*, states that VA NHCU admissions must be categorized into short-stay services or long-stay services and that patients must be placed in the appropriate treating specialty. A patient should be discharged from the NHCU when the patient has met the treatment goals, the facility can no longer accommodate the patient due to a change in the level of care needs, or the patient intentionally disregards medical center policies. Unless they agree, patients who meet the criteria for "long-stay" may not be discharged to another facility or setting if they continue to require nursing home care. Long-stay patients may be discharged if they no longer require nursing home care, such as when they have met

their goals for admission and/or their condition has improved to the extent that they no longer require that level of care.

This delay in discharge of NHCU patients has repercussions throughout the medical center. When the NHCU has no open beds, other units cannot discharge patients that require NHCU care to the NHCU. In turn, this prevents the Intensive Care Units (ICUs), medical and surgical, from discharging patients to the medical units due to lack of available beds. When the ICUs are full, the Emergency Room (ER) must either hold patients requiring ICU or other medical care until a bed is available or divert VA patients to other civilian medical centers in the local area until the ER is able to accept patients. NHCU staff we spoke with identified the following problems with patient flow in the NHCU:

- *Inappropriate Admissions.* Patients that qualify for outpatient or in-home care are admitted to the NHCU despite the NHCU Admission Committee's disapproval of the admission.
- *Continued Stay Criteria Not Met.* Patients who do not require skilled nursing care are not discharged to another level of care.
- *Patients Refuse Discharge.* Patients who no longer require skilled nursing care or who are ineligible for long-term custodial care at VA expense refuse to be discharged. Discharge to another level of care outside of the VA may require patients to pay for some or all of the care they receive, so patients refuse to give social workers personal financial information that would facilitate a discharge.
- *Failure to Use Community Resources.* Increased community nursing home (CNH) contracts would allow the transfer of eligible patients to a CNH while other financial arrangements are coordinated (for example, Medicaid approval). Additional placement of qualified patients at community residential care centers would ensure proper use of NCHU facilities.
- *Reluctance to Follow Due Process Procedures.* When continued nursing care in the NHCU is no longer required, staff report that some patients and families decline to cooperate with a placement outside of the NHCU. When this occurs, the medical center should formally notify patients of the pending termination of care. Patients may present medical

information related to their conditions that would prevent discharge.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that data analyses are reported to the appropriate committees and that specific corrective actions are documented, implemented, and monitored.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director improves the peer review process by documenting required training of all providers conducting peer review, completing initial peer reviews within the 45-day standard and final peer reviews within the 120-day standard, documenting peer review discussions, and tracking and following up on action items.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires tracking and trending of patient complaint data by appropriate committees.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director improves processing times for RCAs.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires completion of staff education on the handoff communication policy.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director enhances review of admission and continued stay cases that do not meet medical center criteria.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires the Patient Flow Committee to meet regularly to continue implementation and evaluation of action plans.

The VISN and Medical Center Directors agreed with the findings and recommendations. Senior management will develop and monitor plans to improve documentation of meeting minutes, provide peer review training for all providers, monitor peer review processing and action plans, track and trend patient complaint data, include RCA timeliness as a performance measure (PM), conduct monthly

reviews of admission and continued stay data, and restructure the Patient Flow Committee to improve operations. We will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center had established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration, and Joint Commission standards. To evaluate EOC, we inspected selected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance.

Overall, we found the facility to be clean and well maintained, and Interim Life Safety Measures were implemented and monitored at all construction sites. However, the following conditions required management attention.

Environment of Care Rounds. EOC rounds of CBOCs were not completed as frequently or by all designated team members, as required by Medical Center Memorandum No. 00-16, *Environmental Rounds*. Team membership consisted of two teams with representation from the following:

- Associate Director or designee (Red Team Leader).
- Associate Director for Patient/Nursing Services or designee (Blue Team Leader).
- Facilities Management Services.
- Safety.
- Biomedical.
- Nursing.
- Infection Control.
- Environmental Management.
- QM/Patient Safety.
- Information Security.
- Radiation Safety.

The EOC team utilized discipline-specific checklist tracking logs to maximize effectiveness while continuously assessing the medical center's environment for functionality, safety, and cleanliness for patients, staff, and visitors. When all

team members participate in rounds, the expertise of each team member is used to identify and correct sanitation discrepancies, unsafe working conditions, and occupational safety and health regulatory violations. We found that not all CBOCs were inspected and that some team members did not participate in the EOC rounds of CBOCs. For example, in March 2007, only two of the four CBOCs were inspected, and in August 2007, two of the CBOCs were inspected by only 4 of 10 team members.

Fire Extinguisher Access. We found that fire extinguishers were locked on 7-East to protect patients and staff from unauthorized patient access. Fire extinguishers could be used as weapons, thus the National Fire Protection Association recognizes that locked fire extinguishers on an acute psychiatric unit may be necessary. However, on 7-East, keys to the locked fire extinguishers were kept in a central location at the front desk. Access to the keys could be compromised if there was a fire in the vicinity of the front desk. Staff members should carry keys to the locked fire extinguishers.

Recommendation 8

We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds, that all CBOCs are inspected semi-annually, and that documentation of EOC rounds is complete.

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires that staff on the 7-East Acute Psychiatric Unit be issued keys to locked fire extinguishers and provided with training on VHA Directive 2005-037, *Planning for Fire Response*, and Medical Center Memorandum No. 138-05, *Fire Plan*.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that a sign-in log for EOC inspection team members will be maintained by the Facility Safety Officer, and a semi-annual report will be provided to the Safety Committee that will include the status of inspections and documentation of participants. A CBOC coordinator has been added to the EOC team to ensure that all CBOCs are inspected twice annually. Keys have been issued to 7-East staff, and staff will receive training on the directive and the memorandum. We will follow up on the planned actions until they are completed.

Patient Satisfaction 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 PM results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 below shows the medical center's SHEP PM results for inpatients.

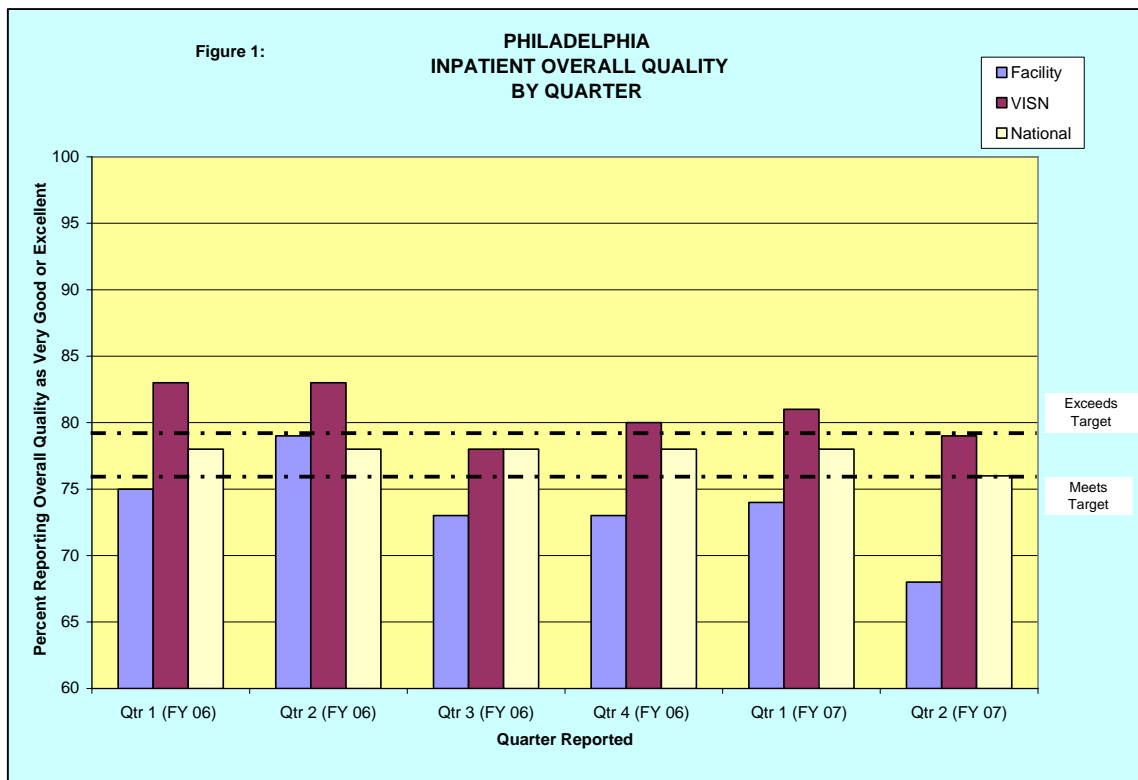
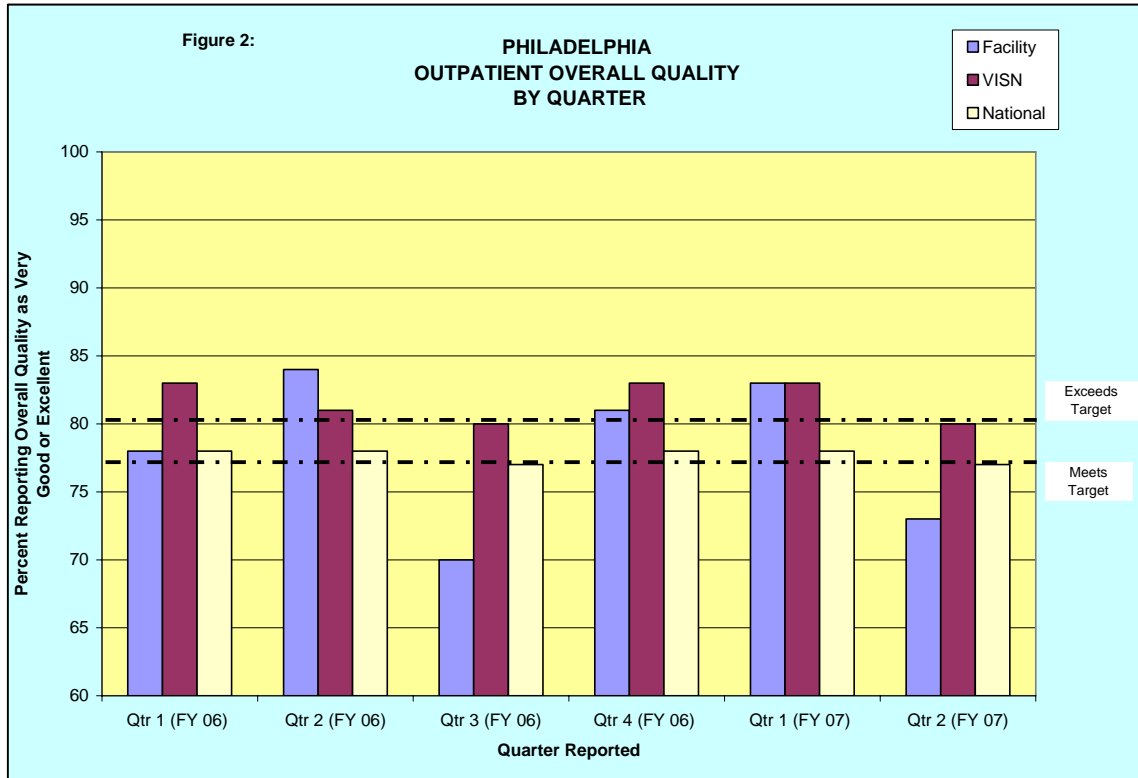


Figure 2 on the next page shows the medical center's SHEP PM results for outpatients.



The medical center exceeded the established target for 4 of the last 6 quarters of available data for outpatient overall quality but only exceeded the established target in 1 of the last 6 quarters for inpatient overall quality. The patient advocate provides customer service training on a regular basis, but it is not widely attended. The Surgical Service has a well-developed action plan in place to improve patient satisfaction, and there are activities for improvement taking place that address issues directly affecting patients. These include trying to improve severe parking problems and CBOC services and implementing a policy for patients who want to change providers. However, the medical center does not have an overall action plan in place—nor do most service lines—despite a medical center directive to develop action plans at the service line level by April 2007. The medical center lacks organized, consistent data on patient complaints for tracking and trending and for comparison with SHEP data scores.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director oversees the development and implementation of an action plan for improvement of patient care based on internal surveys and SHEP data results, with service line and executive-level involvement.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Customer Service Policy will be revised to clearly define membership and reporting responsibilities. We will follow up on the planned action until it is completed.

Computerized Patient Record System Business Rules

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, 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 reflecting accurately the time and date recorded.

A communication (software informational patch⁶ USR*1*26) was sent from VHA's 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.⁷ 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.

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 the medical center had four rules that needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or the Chief of Health Information Management Service.

⁶ A patch is a piece of code added to computer software in order to fix a problem.

⁷ VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

Recommendation 11

We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

The VISN and Medical Center Directors agreed with the finding and recommendation. Medical center staff took action to edit or remove noncompliant business rules while we were onsite. Based on these actions, we consider this recommendation closed.

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 25 patients who had surgery performed during quarters 1 and 2 of FY 2007. The review included medical records for each of the following surgical categories: (a) colorectal, (b) vascular, (c) orthopedic (knee or hip replacement), and (d) hysterectomy.

We evaluated the following VHA PM indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the preceding indicators. To receive fully satisfactory ratings, a facility must achieve the scores summarized in the table below.

Performance Measure	Performance Measure Score
Timely antibiotic administration	90 percent
Timely antibiotic discontinuation	87 percent
Controlled body temperature – colorectal surgery	70 percent

Our review showed that the medical center appropriately administered and discontinued antibiotics or documented clinical reasons why this did not occur. Clinicians controlled immediate post-operative body temperature for patients who had colorectal surgery performed. Results are displayed in the table below.

Antibiotic given timely	Antibiotic stopped timely	Body temperature control (colorectal surgery)
100 percent (25/25)	100 percent (25/25)	100 percent (5/5)

When PMs fell below VHA targets, managers developed and implemented acceptable improvement strategies. They continuously monitor the efficacy of the improvement strategies.

Our review also showed that there is a lack of consistent documentation in the care of post-anesthesia patients. A computerized flow sheet intended for patients in a critical care setting was used for some patients, and a paper form was used for other patients, leading to inconsistencies in documentation of patient data for post-anesthesia care. According to staff, a template has been developed for the post-anesthesia area but has not yet been put into use.

Recommendation 12

We recommended that the VISN Director ensure that the Medical Center Director requires consistency in medical record documentation through the use of CPRS templates developed specifically for patients receiving post-anesthesia care.

The VISN and Medical Center Directors agreed with the finding and recommendation and will begin staff training to ensure use of the electronic database to document patient care. We will follow up on the planned action until it is completed.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 24, 2007

From: VISN 4 Director

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

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

Director, Management Review Office (10B5)

1. I concur with the facility Director's response to the OIG recommendations. Please note the clarification that the Behavioral Health unit that OIG visited during the review was located on 7-East.
2. Thank you for the review of our program in Philadelphia.

(original signed by:)

MICHAEL E. MORELAND, FACHE

VISN 4 Network Director

Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: October 23, 2007

From: Philadelphia VA Medical Center Director

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

To: Network Director, VISN 4

1. I have reviewed and concur with the CAP recommendations.
2. There is one issue that requires clarification. This is located under Environment of Care, Fire Extinguisher Access, and Recommendation 9. The inspectors visited 7-East, our newly renovated unit. 7-West was closed on September 7th, and those patients were transferred to the newly constructed unit on 7-East. *(Corrections have been made to the report to reflect the right unit).*
3. I have noted my concurrence with the actions on the following pages. I have also entered in our proposed actions to correct the issues.
4. I would like to thank the CAP team for their review of our facility. We found them to be very fair and professional.

(original signed by:)

Richard S. Citron, FACHE

Director, Philadelphia VA Medical Center

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 data analyses are reported to the appropriate committees and that specific corrective actions are documented, implemented, and monitored.

Concur

Facility Response: MCM 00-01 will be updated to include a mandated template for minutes that will include Issue, Discussion/Recommendation, Action Plan/Responsibility, and Status. This will ensure standardization of the minutes as well as assign responsibility for closure. Minutes will be reviewed by the QUAD. Data analysis will be included in the committee minutes. Target date for completion is 12/1/07.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director improves the peer review process by documenting required training of all providers conducting peer review, completing initial peer reviews within the 45-day standard and final peer reviews within the 120-day standard, documenting peer review discussions, and tracking and following up on action items.

Concur

Facility Response: Mandatory training for all providers will be developed and documented in TEMPO. Target date for completion is 12/15/07. ACOS, clinical product lines, will ensure that reviews are completed within the timeframe designated. Peer review turn around times will be presented quarterly to Medical Executive Committee to improve compliance. Target completion date is 12/15/07. Peer Review minutes will track action items until completion. Open action items will be reviewed each meeting and documented in the minutes. Target date for completion is November 13, 2007.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires tracking and trending of patient complaint data by appropriate committees.

Concur

Facility's response: Customer Service Committee Policy will be rewritten to ensure appropriate membership is on that committee and that patient complaint data is tracked, trended and that results are reported to Quality Council. Target date: 11/15/07.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director improves processing times for RCAs.

Concur

Facility Response: RCA chairperson will provide processing time information to the Leadership when presenting their report. RCA timeliness will be a performance measure for the Patient Safety Staff. Target date for completion: 11/15/07.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires completion of staff education on the handoff communication policy.

Concur

Facility Response: Handoff Communication Policy has been completed and distributed. All clinical staff will be educated regarding this policy. Target date for completion of education: 12/31/07.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director enhances review of admission and continued stay cases that do not meet medical center criteria.

Concur

Facility Response: One additional UR FTEE has been hired; one additional FTEE is proposed. Target date for completion: 12/31/07.

UR program manager will meet with ACOS of clinical service lines on a monthly basis to review performance related to the Interqual criteria. Actions plans will be required of any service that fails to meet the standards. This information will be reviewed at Quality Council on a quarterly basis. Target date for completion: 11/30/07.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires the Patient Flow Committee to meet regularly to continue implementation and evaluation of action plans.

Concur

Facility Response: Patient Flow Committee (now called Bed Allocation Leadership group) has been revamped to include key medical center

leaders. Meeting schedule will be established. Minutes of meeting will be prepared with actions assigned and tracked for completion. Target completion date: 11/15/07.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated EOC team members participate in all EOC rounds, that all CBOCs are inspected semi-annually, and that documentation of EOC rounds is complete.

Concur

Facility Response: Sign-in log for EOC team inspection members will be maintained by Facility Safety Officer. A semi-annual report will be provided to the Safety Committee regarding status of inspections & documentation of participants. Target date for completion: 11/15/07.

A CBOC coordinator has been appointed to the EOC team that visits CBOCs to ensure that all CBOCs are inspected twice annually. Target date for Completion: 10/15/07 (Completed).

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that staff on the 7-East Acute Psychiatric Unit be issued keys to locked fire extinguishers and provided with training on VHA Directive 2005-037, *Planning for Fire Response*, and Medical Center Memorandum No. 138-05, *Fire Plan*.

Concur

Facility Response: *Clarification: 7-West was closed on September 7th, 2007. All 7-West patients were transferred to the newly constructed unit on 7-East. 7-East was the area inspected by the CAP team. (The OIG recommendations were changed to reflect the correct unit).*

Keys have been issued to 7-East Acute psychiatry staff. Action completed 9/24/07.

7-East staff will receive training regarding VHA Directive 2005-037 and MCM138-05. Target date for completion: 11/30/07.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director oversees the development and implementation of an action plan for improvement of patient care based on internal surveys and SHEP data results, with service line and executive-level involvement.

Concur

Facility Response: Customer Service Policy will be revised and membership clearly defined. Representative from Clinical services will report quarterly to the Customer Service Committee regarding their findings from internal surveys and SHEP data with corrective action plans.

Information will flow from Customer Service Committee to Quality Council.
Target date for completion: 12/30/07.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur

Facility Response: The four rules identified by CAP were changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or Chief, HIMS. Action completed 9/21/07. Compliance with VHA handbook 1907.1 will be maintained.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires consistency in medical record documentation through the use of CPRS templates developed specifically for patients receiving post-anesthesia care.

Concur

Facility Response: Staff is being educated to use the electronic database (Careview) to document in the medical record. Target completion date: 12/1/07.

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