Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03173-145

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

June 12, 2008

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of April 21–25, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Providence VA Medical Center (the medical center), Providence, RI. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training for 243 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

This CAP review covered five operational activities. We also followed up on two review areas from the May 2005 CAP review. We identified the following organizational strengths and reported accomplishments**:**

- Clinical managers established a homeless oriented primary care clinic, which increased access and improved care for this population.
- Clinical managers implemented a medication reconciliation program in clinical areas.

We made recommendations in four of the activities reviewed and in one of the follow-up review areas. For these four activities and the follow-up review area, medical center managers needed to:

- Implement a facility peer review policy and establish a peer review committee.
- Ensure that a continuous performance monitoring plan be implemented, adequate performance improvement (PI) data be provided by contract agencies, and provider PI data be analyzed prior to reprivileging.
- Ensure that the physician advisor reviews the medical records of patients who do not meet standardized admission and continued stay criteria.
- Ensure that clinical data are analyzed and consistently reported in a manner that will identify trends over time.
- Ensure that controlled substances (CS) inspectors validate two CS transfers from one area to another during monthly inspections.

- Ensure that CS inspectors verify that change of shift counts for non-automated dispensing units and weekly inventories of all automated units are completed during monthly inspections.
- Ensure that CS inspectors reconcile 1 day's dispensing activity from the main pharmacy to the automated units during their monthly inspections.
- Ensure that a ballistic window is installed in the outpatient pharmacy's dispensing counter.
- Ensure that nursing managers properly group patients known to be infected or colonized with transmissible microorganisms.
- Ensure that medication expiration dates are checked regularly and expired medications are removed from working medication stock.
- Ensure that refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance and repairs.
- Ensure that managers regularly review computerized patient record system (CPRS) business rules to ensure compliance with Veterans Healthcare Administration (VHA) regulations.
- Ensure that skin care interventions are consistently documented and data analysis includes trending for the effectiveness of skin care interventions.

The medical center complied with selected standards in the following activity:

- 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 Acting 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 provides a broad range of inpatient and outpatient health care services to veterans residing in Rhode Island and southeastern Massachusetts. It also provides outpatient services at three community based outpatient clinics (CBOCs) in Middletown, RI, and in New Bedford and Hyannis, MA. The medical center is part of VISN 1 and serves a veteran population of more than 31,000 patients.

Programs. The medical center is a primary and secondary health care facility and provides comprehensive health care services in medicine, surgery, and psychiatry.

Affiliations and Research. The medical center is affiliated with Brown University's School of Medicine and Boston University's School of Medicine and provides training for 300 residents, interns, and medical students per year. The medical center also provides training for students in nursing and other health professions, such as pharmacy, social work, optometry, and psychology. The medical center's research program has an annual budget of $8 million. It has approximately 140 projects and 52 principal investigators. Major areas of research include oncology, cardiology, mental health, dermatology, neuroscience, substance abuse, and pulmonary diseases. The medical center is also a Rehabilitation Research Center of Excellence.

Resources. In fiscal year (FY) 2007, the medical center's medical care budget totaled over $122.7 million; for FY 2008, the medical care budget is more than $142 million. FY 2008 staffing is 882 full-time employee equivalents (FTE), including 67 physician and 204 nursing FTE.

Workload. During FY 2007, the medical center treated 28,500 unique patients and provided over 20,000 inpatient days. It had 66 operating hospital beds and an average daily census of 56. Outpatient workload for FY 2007 totaled approximately 295,000 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:

- 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. This review covered the following five activities:

- CPRS Business Rules.
- Environment of Care (EOC).
- Pharmacy Operations.
- QM Program.
- SHEP.

The review covered medical center operations for FY 2007 and quarter 1 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 Providence VA Medical Center, Providence, Rhode Island,* Report No. 05-01607-68, January 31, 2006). In that report, we had identified improvement opportunities in EOC and pressure ulcer prevention and management. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the identified EOC deficiencies, and we consider those issues closed. However, since desired results for pressure ulcer management documentation and data analysis had not been completely achieved, we issued a recommendation for this area (see pages 12–13).

During this review, we presented fraud and integrity awareness briefings for 243 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Organizational Strengths

Homeless Veterans Primary Care Clinic

The medical center established a homeless oriented primary care clinic. The program offers open access by allowing veterans to walk in without appointments during clinic hours. In addition to open access to primary care services, the program offers case management and integration with other homeless services, such as behavioral health care, housing, compensated work therapy (CWT) services, and VA benefits information.

There are 140 homeless veterans currently enrolled in the program, with Operation Enduring Freedom/Operation Iraqi Freedom veterans accounting for 10 percent of the enrollment. In their initial 6 months of enrollment in the clinic, veterans averaged more than three primary care visits and had a 53 percent decrease in emergency department (ED) visits. Additionally, enrollees showed a 10 percent decrease in medical center admission rates by their second 6 months in the program. Clinical data shows improvement in these veterans' overall health, and clinical managers reported that these veterans are more likely to be referred to behavioral health, housing, and CWT services.

Medication Reconciliation

In 2007, the medical center conducted an analysis of its performance with medication reconciliation across the continuum of care, which is a VHA and Joint Commission (JC) patient safety goal. The Director chartered an interdisciplinary process action team to develop strategies for improvement. At the time of our visit, the new strategies were implemented in the ED, primary care, home-based primary care, all inpatient units, behavioral health care service areas, and specialty clinics.

A survey of 100 primary care patients who saw providers on March 10, 2008, showed that for 97 percent of the patients interviewed, providers discussed all medications with the patients, gave the patients lists of their medications, and educated the patients regarding changes in their medications.

Results

Review Activities With Recommendations

Quality Management Program

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

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. We identified the following areas that needed improvement.

Peer Review. In 2004, VHA regulations[1] required that VA health care facilities develop and implement facility-level peer review policies and establish peer review committees. VHA reinforced these requirements in its new directive published in January 2008.[2]

The medical center did not have a specific peer review policy, as required. Rather, the peer review process was addressed in a section of the medical center's patient safety policy,[3] and that section primarily addressed tort claims. While the medical center did have an adequate peer review process in place, senior managers had not established a peer review committee, as required by VHA. VHA gives specific guidance as to the responsibilities of the peer review committee, such as meeting at least quarterly, training reviewers, trending peer review results, and reporting quarterly to medical staff executives. These responsibilities were not completely met.

[1] VHA Directive 2004-054, *Peer Review for Quality Management*, September, 29, 2004.
[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[3] Policy Memorandum 00QM-7, *Patient Safety Improvement and Sentinel Events Program*, August 27, 2007.

Provider Performance Monitoring. VHA regulations[4] and JC medical staff standards require that clinical managers collect and review provider performance data as part of the reappraisal and reprivileging process of medical staff members. According to VHA and the JC, reappraisal data should be ongoing, include indicators of continuing qualifications and competencies, and be reviewed and considered during the reprivileging process (the process of evaluating professional credentials and clinical competencies of practitioners who hold clinical privileges in the medical center).

We reviewed credentialing and privileging folders and corresponding PI monitoring data for 11 providers reprivileged in the past 12 months and found that 2 of 11 did not have adequate PI data. One provider was a contract radiologist. The contracting agency was to provide PI data for review prior to the radiologist being reprivileged. The agency did not provide adequate data, but clinical managers reprivileged the radiologist. If contract agencies are to provide PI data, the agencies need to be held to VHA standards. The second provider was a medical center employee reprivileged in April 2007. A review of this clinician's PI folder indicated that the PI monitoring data were signed and dated as having been reviewed after the clinician was reprivileged.

At the time of our review, senior clinical managers were in the process of developing plans for continuous performance monitoring. Once implemented, these plans should ensure that providers' qualifications and competencies are appraised on an ongoing basis, resulting in sufficient PI data for each provider at the time of reprivileging.

Utilization Management. VHA regulations[5] and medical center policy[6] require that a designated physician advisor review medical records of patients who do not meet standardized admission and continued stay criteria. At the time of our review, these cases were not being referred to the designated physician advisor for review.

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[5] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[6] Policy Memorandum-00QM-4, *UM (Utilization Management) Program*, June 21, 2005.

Data Analysis. We reviewed minutes from several of the medical center's committees that oversee clinical operations. It was clear that the medical center collected large amounts of data; however, data were not consistently trended in a manner that allowed for in-depth analysis. A review of monthly and/or quarterly data reports showed that data were frequently reported in a narrative format, which did not allow for the display of comparative information over time. Consequently, it was difficult to determine how opportunities for improvement were identified.

Recommendation 1 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that clinical managers implement a facility peer review policy and establish a peer review committee that will fulfill all the functions required by VHA.

Recommendation 2 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that a continuous performance monitoring plan be timely implemented, performance data provided by contract agencies meet VHA standards, and provider PI data be available and analyzed prior to reprivileging.

Recommendation 3 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that the designated physician advisor review the medical records of patients who do not meet standardized admission and continued stay criteria.

Recommendation 4 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that clinical data are analyzed and consistently reported in a manner that will identify trends over time.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations. They reported that clinical managers implemented a peer review policy and established a peer review committee, in accordance with VHA regulations. A performance monitoring plan was presented to the medical staff. The medical staff accepted the plan, and it is currently being implemented. Additionally, managers are in the process of reviewing clinical contracts to ensure that contract language meets VHA standards for performance monitoring.

The Directors also reported that a designated physician advisor will review the medical records of patients who do not meet standardized admission and continued stay criteria. Additionally, they reported that managers conducted an analysis that identified individuals responsible for data management who need training or re-training in the use of continuous quality improvement tools. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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 pharmacies' 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[7] governing pharmacy and CS security, and we assessed whether the medical center's policies and processes were consistent with VHA regulations. We reviewed the CS inspection program and inspected inpatient and outpatient pharmacies for security, EOC, and infection control (IC) issues. In addition, we interviewed CS inspectors and appropriate Pharmacy Service and Police and Security Service managers.

Our review showed that the medical center's policies and processes were effective in ensuring the security of the pharmacies and CS. The CS inspection program complied with many of VHA's inspection procedures, such as issuing CS inspector appointment letters and ensuring that training requirements for the CS Coordinator and CS inspectors were met. In addition, required monthly inspections included CS counts in the pharmacies, on inpatient units, in outpatient clinics, and in the animal research laboratory. Monthly inspections verified that pharmacy staff completed 72-hour inventories of CS, and we found that managers reported suspected diversions to the OIG. However, we identified areas that would improve controls over the medical center's pharmacy operations.

[7] 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.

We were unable to determine if inspectors validated two CS transfers from one area to another or if they verified that change of shift counts for non-automated dispensing units were completed, as required. In addition, we could not verify if inspectors confirmed that weekly inventories of the automated medication dispensing units were completed or if inspectors reconciled 1 day's dispensing activity from the main pharmacy to the automated units, as required.

The inpatient and outpatient pharmacy areas were generally clean and well maintained; however, we found that the outpatient pharmacy's dispensing counter did not have a ballistic (bulletproof) window, as required by VA regulations.[8] Staff told us that the current window structure was more conducive to customer service; however, the requirement is intended for staff protection.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[9] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[10] We interviewed pharmacy clinical managers to determine the medical center's efforts to monitor and avoid inappropriate polypharmacy.

Our review showed that clinical pharmacists identified patients who were prescribed multiple medications, reviewed the patients' medication regimens to avoid complications

[8] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000; VA Handbook 0730/1, *Security and Law Enforcement*, August 20, 2004.
[9] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[10] 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.

related to polypharmacy, and advised providers regarding potential polypharmacy complications when appropriate.

Recommendation 5 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors validate two CS transfers from one area to another during monthly inspections.

Recommendation 6 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors verify that change of shift counts for non-automated dispensing units and weekly inventories of the automated units are completed during their monthly inspections.

Recommendation 7 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors reconcile 1 day's dispensing activity from the main pharmacy to the automated unit during their monthly inspections.

Recommendation 8 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that a ballistic window that meets VA regulations be installed in the outpatient pharmacy's dispensing counter.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations. They reported that CS inspectors will validate two CS transfers, verify change of shift counts for non-automated dispensing units and weekly inventories of automated units, and reconcile 1 day's dispensing activity from the main pharmacy to the automated units during monthly CS inspections.

The Directors also reported that managers ordered a ballistic window and that construction and installation will be completed by September 2008. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards. We inspected the following patient care areas: (a) the acute telemetry/medical surgical unit, (b) the intensive care unit, (c) an acute medical surgical unit, (d) the locked acute inpatient psychiatric unit,

(e) the continuity of care outpatient clinic, (f) the dental clinic, (g) the ambulatory diagnostics and treatment unit (ADTU), and (h) the New Bedford CBOC.

The medical center maintained a generally clean and safe environment. Risk assessments complied with VHA standards. Additionally, managers on the locked acute inpatient psychiatric unit complied with safety regulations and trained staff to identify environmental hazards. While managers had resolved the EOC deficiencies from the previous CAP review, we identified the following areas that needed improvement.

Infection Control. The IC program monitored and reported data to clinicians, and the data were used to implement quality of care improvements. However, we found one issue on the telemetry/medical surgical unit. A patient who was on contact isolation[11] shared a bathroom with two patients in the adjoining room who were not on isolation precautions. The Centers for Disease Control and Prevention[12] and medical center guidelines recommend cohorting[13] patients to prevent the transmission of multidrug-resistant organisms to uninfected but susceptible patients. Use of the shared bathroom had not been restricted, and managers did not instruct the patients in the non-isolation room that they should not use the bathroom. Both patients in the non-isolation room reported that they had used the bathroom.

Safety. We found a box with three expired vials of tetanus toxoid/diphtheria toxoid in the working stock of the continuity of care outpatient clinic refrigerator. Expired medications may lose effectiveness, and their efficacy cannot be assured past the listed expiration date.

In all areas toured, with the exception of the ADTU, the refrigerator monitoring logs did not indicate normal temperature ranges for the medications or food items within. In addition, none of the medication or food refrigerator temperature logs we inspected provided contact information in the event that refrigerators malfunctioned.

[11] Contact isolation isolates patients with known or suspected infections or evidence of syndromes that represent an increased risk for transmission to vulnerable patients.
[12] Jane D. Siegel, et al., *Management of Multidrug-Resistant Organisms in Healthcare Settings*, Centers for Disease Control and Prevention, Atlanta, 2006.
[13] This term applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients.

Recommendation 9 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that nursing managers properly cohort patients known to be infected or colonized with transmissible microorganisms.

Recommendation 10 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that medication expiration dates be checked regularly and that expired medications be removed from working medication stock.

Recommendation 11 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance and repair.

The Acting VISN and Medical Center Directors agreed with the findings and recommendations. They reported that the medical center's policy requires cohorting of patients, and clinical managers will increase the frequency of monitoring to ensure compliance. They also reported that the Nursing Service and the Pharmacy Service will collaboratively monitor inpatient and outpatient medication stock and report findings to the QM Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Additionally, managers implemented a new temperature log format that reflects the requirements of the OIG recommendation. The corrective action is acceptable, and we consider Recommendation 11 closed.

Computerized Patient Record System Business Rules

Business rules define which groups or individuals are allowed to edit, amend, or delete documentation in electronic medical records. The health record, as defined in VHA regulations,[14] includes both the electronic and paper medical record. It includes items, such as physician orders, progress notes, and examination and test results. In general, once progress notes are signed, they should not be altered.

On October 20, 2004, VHA's Office of Information (OI) sent software informational patch USR*1*26 to all medical centers and systems with instructions to assure that business rules complied with VHA regulations. The guidance cautioned that "the practice of editing a document that was signed by the author might have a patient safety implication and should not

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

be allowed." In January 2006, the OIG identified a facility where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors instructing all VA health care facilities to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center information and technology policies and interviewed Clinical Information Systems staff. We determined that one business rule needed to be removed to limit deletion of notes to the Chief of Health Information Management Service (HIMS), as required by VHA. Managers took action to remove the rule while we were onsite.

Recommendation 12 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that managers regularly review CPRS business rules to ensure compliance with VHA regulations.

The Acting VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the Chief of HIMS and the Clinical Applications Coordinator will review CPRS business annually and report findings to the Medical Records Committee. The corrective action is acceptable, and we consider this recommendation closed.

Pressure Ulcer Prevention and Management

We followed up on the recommendations regarding pressure ulcer prevention and management from the previous CAP review. In the report, we recommended that managers develop and implement a comprehensive skin care policy and collect and analyze pressure ulcer data for trends and effectiveness of interventions.

The medical center established an interdisciplinary Skin Care Committee in January 2005 and published and implemented a skin care policy in July 2005. The medical center revised the policy in 2008. Additionally, management established a wound care specialist position.

We reviewed five medical records of patients who had pressure ulcers and found that pressure ulcer risk assessments were completed. We also found that the wound care specialist assessed patients' pressure ulcers and recommended treatment interventions. While the medical center implemented processes to improve assessment and management of pressure ulcers and

analysis of pressure ulcer data, we identified areas that needed improvement.

In four of the five medical records, we found that pressure ulcer treatment interventions were not consistently documented. Additionally, we found that determining the effectiveness of skin care interventions could be improved by collecting data on the status of pressure ulcers, for example, whether they improved or worsened.

Recommendation 13 We recommended that the Acting VISN Director ensure that the Medical Center Director requires that skin care interventions are consistently documented and that data analysis includes trending for the effectiveness of skin care interventions.

The Acting VISN and Medical Center Directors agreed with the findings and recommendation. They reported that the medical center's skin care policy was updated to comply with VHA regulations and that nursing managers referenced "best practice" models from other facilities to improve data tracking and trending. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Survey Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities use 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 the target scores for all quarters. Outpatient scores met or exceeded the target in 3 of the 4 quarters reviewed. Findings are displayed in the graphs on the next page.

Figure 1:

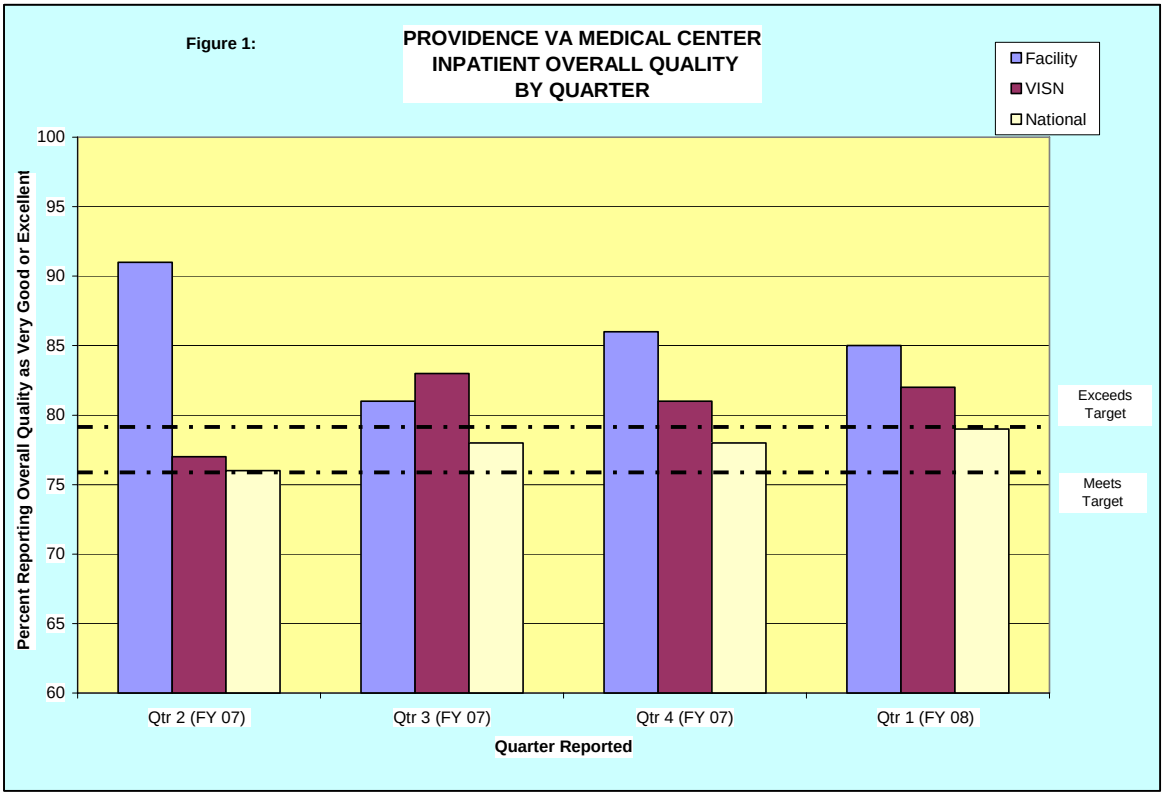
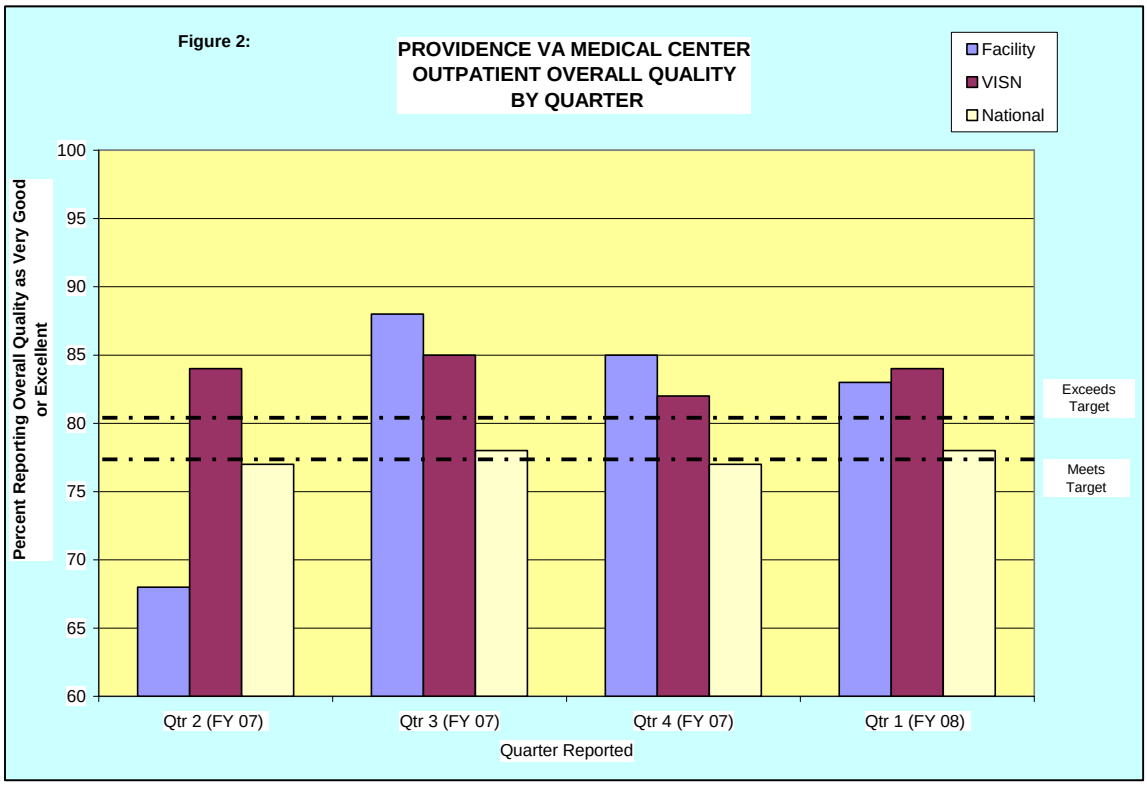


Figure 2:



Medical center managers analyzed their survey results, developed improvement strategies, and monitored the results of the strategies. Survey results and improvement strategies were disseminated throughout the organization, and medical center scores indicate that the strategies were effective.

We made no recommendations.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2008

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

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

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

Director, Management Review Service (10B5)

We concur with IG's findings and recommendations. Please see attached responses.

For additional information, please contact Allan Shirks, MD, VISN 1 QMO, 781-687-4850.

(original signed by:)

Tammy Follensbee

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2008

From: Director, Providence VA Medical Center (650/00)

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

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

Director, Management Review Service (10B5)

Please find our responses to all recommendations noted in the Combined Assessment Program Review Report for the Providence VA Medical Center.

(original signed by:)

VINCENT NG

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 Acting VISN Director ensure that the Medical Center Director requires that clinical managers implement a facility peer review policy and establish a peer review committee that will fulfill all the functions required by VHA.

Concur

A revised facility policy and plan for implementation of peer review committee, in compliance with VHA Directive 2008-040, was finalized. The first meeting of a separate peer review committee occurred on May 21. All peer review committee members are trained in accordance with committee functions. Recommend that this recommendation be considered closed.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that a continuous performance monitoring plan be timely implemented, performance data provided by contract agencies meet VHA standards, and provider PI data be available and analyzed prior to reprivileging.

Concur

Facility policies for credentialing and privileging and a medical staff performance monitoring plan for privileging and reprivileging have been developed, presented to Service Chiefs and to the Medical Staff, and have been accepted. They are being implemented currently. Clinical contracts are in process of being re-reviewed to ensure contract language meets the VHA standards for contract agency provider performance monitoring. Timetable for completion: by June 30, 2008.

Recommendation 3. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that the designated physician advisor review the medical records of patients who do not meet standardized admission and continued stay criteria.

Concur

A physician advisor has been identified, and a facility procedure has been implemented for the physician advisor to review medical records of patients not meeting standardized admission and continued stay criteria. Completed on May 30. Recommend closeout of this recommendation.

Recommendation 4. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that clinical data are analyzed and consistently reported in a manner that will identify trends over time.

Concur

The facility will intensify its efforts to ensure consistency of data analysis, trending, and reporting by the following: A gap analysis has been conducted and areas of improvement identified for training and retraining of individuals responsible for data management, analysis, and trending in all services, medical staff committees, and clinical units. The training program will be implemented utilizing appropriate CQI tools and concepts to address current and future opportunities for improvement. Timeline for completion: August 2008.

Recommendation 5. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors validate two CS transfers from one area to another during monthly inspections.

Concur

The facility will ensure that the controlled substances (CS) inspections are conducted according to the existing facility policy and procedures, and inspection teams will now check off on the existing documentation templates, validation of the two CS transfers during their monthly inspections. Timeline for completion: June 30, 2008.

Recommendation 6. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors verify that change of shift counts for non-automated dispensing units and weekly inventories of automated units are completed during their monthly inspections

Concur

The facility will ensure that the Controlled Substances Inspections are conducted according to the existing facility policy and procedures and that inspection teams will now check off on the existing documentation templates, verification that change of shift counts for non-automated dispensing units and weekly inventories of automated units are completed during their monthly inspections. Timeline for completion: June 30, 2008.

Recommendation 7. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that CS inspectors reconcile 1 day's dispensing activity from the main pharmacy to the automated units during their monthly inspections.

Concur

The facility will ensure that the Controlled Substances Inspections are conducted according to the existing facility policy and procedures and that inspection teams will now check off on the existing documentation templates, that they have reconciled 1 day's dispensing activity from the main pharmacy to the automated units during their monthly inspections. Timeline for completion: June 30, 2008.

Recommendation 8. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that a ballistic window that meets VA regulations be installed in the outpatient pharmacy's dispensing counter.

Concur

The required modification is now on order. Construction will be completed by September 2008.

Recommendation 9. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that nursing managers properly cohort patients known to be infected or colonized with transmissible microorganisms.

Concur

The facility's current policy requires cohorting of patients who are infected or colonized with transmissible microorganisms. The facility will increase the frequency of infectious control monitoring and education activities to ensure compliance with local policy. Timeline for implementation: May 2008.

Recommendation 10. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that medication expiration dates be checked regularly and that expired medications be removed from working medication stock.

Concur

Current facility policy requires that medication expiration dates be routinely checked and that expired medications be removed from working medication stocks. Nursing/Nurse Managers and Pharmacy will now collaboratively monitor stock in all outpatient and inpatient medication

storage areas and report progress on compliance to Quality Management Committee and/or Pharmacy and Therapeutics Committee. Timeline for completion: May 30, 2008. We recommend that this recommendation be closed.

Recommendation 11. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that refrigerator logs reflect acceptable temperature ranges and include contact information for maintenance and repair.

Concur

A standard temperature log compliant with the requirements has already been implemented for all inpatient areas, and the responsible staff and managers have been informed. Assessment of all refrigerators throughout the facility is in the process of being conducted through Environment of Care rounds, and standard temperature logs will replace any that are non-conforming. Timeline for completion: May 30, 2008. We recommend that this recommendation be closed.

Recommendation 12. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that managers regularly review CPRS business rules to ensure compliance with VHA regulations.

Concur

The facility will ensure that the procedure for review of CPRS Business Rules is followed, results of review are reported through Medical Records Committee. Chief, HIMS, and the Clinical Applications Coordinator will now review any changes to the Business Rules on an annual basis. Timeline for completion: May 30, 2008. We recommend that this recommendation be closed.

Recommendation 13. We recommended that the Acting VISN Director ensure that the Medical Center Director requires that skin care interventions are consistently documented and that data analysis includes trending for the effectiveness of skin care interventions.

Concur

Our policy states that we assess Pressure Ulcers shift to shift, and there is an expectation of documentation on all shifts. Local policy was changed to conform to VHA Directive as were the templates to reflect measurement of ulcers in addition to staging changes. Tracking and trending data, in addition to our graphics representations of overall rates by units, has been augmented. The facility has referenced Best Practice models from other facilities in augmenting our data tracking and trending. Completed by May 30, 2008. We recommend that this recommendation be closed.

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