Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02066-266

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

September 2, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
EHR	electronic health record
EOC	environment of care
facility	Providence VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
PT/INR	prothrombin time and international normalized ratio
PTT	partial thromboplastin time
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 16, 2014.

Review Results: The review covered six activities. We made no recommendations in the following three activities:

- Medication Management
- Coordination of Care
- Magnetic Resonance Imaging Safety

The facility's reported accomplishments were Compensation and Pension Systems redesign, accreditation by the Commission on Cancer, and Pathway to Excellence® designation by the American Nurses Credentialing Center.

Recommendations: We made recommendations in the following three activities:

Quality Management: Report completed actions from peer reviews to the Peer Review Committee. Ensure the Special Care Committee collects data that measures performance in responding to codes. Require the Surgical Service Staff Committee to meet monthly and the Blood Usage Review Committee to meet at least quarterly. Include the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria in the blood/transfusions usage review process. Ensure that when data analysis indicates problems or opportunities for improvement, actions are consistently identified, implemented, and followed to resolution in surgical performance improvement activities, electronic health record quality reviews, and blood/transfusion reviews.

Environment of Care: Ensure all patient care areas and public rest rooms are clean. Follow procedures for terminal cleaning of patient rooms. Ensure that in patient care areas, damaged furniture is repaired or removed from service and damaged surfaces are repaired. Bring the pharmacy clean room for compounding sterile products into compliance with United States Pharmacopeia <797> cleanliness, sterility, and monitoring standards. Ensure all required members of the Environment of Care Committee consistently attend committee meetings, and strengthen the program to ensure effective surveillance activities. Require VA Police to update the Security Management Plan annually and to submit quarterly security reports to the Environment of Care Committee.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient, and screen patients for difficulty swallowing prior

to oral intake. Provide printed stroke education to patients upon discharge. Ensure assessment of patients presenting with stroke symptoms includes facility required blood tests.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012, FY 2013, and FY 2014 through June 13, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment*

Program Review of the Providence VA Medical Center, Providence, Rhode Island, Report No. 12-00708-171, April 27, 2012).

During this review, we presented crime awareness briefings for 13 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 343 responded. We shared summarized results with facility managers.

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.

Reported Accomplishments

Compensation and Pension

By using the techniques of systems redesign and considering the Veterans Benefits Administration as one of its customers, the Compensation and Pension Department has significantly improved the timeliness and quality of exams. Department personnel have worked to decrease veteran claims processing times to a current average of 12 days. Daily communication between the two organizations has led to a constructive relationship that benefits veterans. This strong customer service effort has been recognized with an I Care Award from VISN 1 in 2013 and 2014 and a Gold Award from the VHA Office of Disability and Medical Assessment in 2014.

Cancer Program

The facility has one of two cancer programs in VISN 1 accredited by the American College of Surgeons' Commission on Cancer. Accreditation requires the maintenance of a cancer registry, which is of great research value since data on veterans with cancer is not routinely submitted to state and national cancer registries. The facility registry is maintained by a Certified Tumor Registrar, and data is submitted to the commission in accordance with College of American Pathology protocols. A multidisciplinary cancer committee meets at least four times annually. Accreditation contributes to the quality of care for veterans by providing tumor boards; access to psychosocial, rehabilitation, and nutrition services; psychosocial distress screening; and survivorship care plans. Patients are also informed about clinical trials, and at least 2 percent of patients are enrolled in trials annually.

Pathways to Excellence

In March 2014, the facility became the second VA facility in the country to receive the American Nurses Credentialing Center Pathway to Excellence® designation, an accomplishment achieved by only 9 percent of hospitals nationwide. The designation recognizes positive practice environments where nurses excel and requires rigorous practice standards such as nursing control over nursing practice, a safe and healthy work environment, and systems to address patient care and practice concerns.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • None of the six completed actions were reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Twelve months of Special Care Committee meeting minutes reviewed: • There was no evidence that data were collected to measure performance in responding to events.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Service Staff Committee only met 4 times over the past 6 months.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (Continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	• The Blood Usage Review Committee only met twice in 12 months. Two months of Blood Usage Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	• Corrective actions were not consistently taken, implemented, and followed to resolution for surgical performance improvement activities, EHR quality reviews, and blood/transfusion review issues.
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that completed actions from peer reviews are reported to the Peer Review Committee.

2. We recommended that processes be strengthened to ensure that the Special Care Committee collects data that measures performance in responding to codes.

3. We recommended that the Surgical Service Staff Committee meet monthly.

4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee meets at least quarterly and that the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

5. We recommended that processes be strengthened to ensure that when data analysis indicates problems or opportunities for improvement, actions are consistently identified, implemented, and followed to resolution in surgical performance improvement activities, electronic health record quality reviews, and blood/transfusion reviews.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the medical/surgical, telemetry, intensive care, and behavioral health inpatient units. We also inspected the emergency department; the inpatient pharmacy; the PACU; SDS; and the primary care, eye, dialysis, and women's health clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 23 employee training records (11 SDS, 7 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
X	Environmental safety requirements were met.	• Floors needed cleaning in seven of nine patient care areas and several public restrooms, and two of nine patient care areas had damaged floor tiles. • We found blood stained gauze and tape in the shower of an unoccupied patient room reported as terminally cleaned. • We found damaged furniture in three of nine patient care areas. • Surfaces around hand sinks in primary care exam rooms were worn or damaged to the point where they could not be effectively sanitized. • The pharmacy clean room for compounding sterile products was not compliant with United States Pharmacopeia <797>[1] cleanliness, sterility, and monitoring standards.

[1] United States Pharmacopeia Chapter <797>, Pharmaceutical Compounding of Sterile Preparations, details the procedures and requirements for compounding sterile preparations and sets standards that are applicable to all practice settings in which sterile preparations are compounded.

NM	Areas Reviewed for General EOC (continued)	Findings
	Fire safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on the EOC program reviewed: • The chairperson and other key members of the EOC Committee had limited or no attendance at committee meetings. • EOC rounds failed to adequately identify deficiencies related to general housekeeping and cleanliness. Local policy on the Security Management Plan reviewed: • The facility's required annual Security Management Plan was last updated in 2012. • VA Police did not provide quarterly security reports to the EOC Committee.
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	

NM	Areas Reviewed for Eye Clinic (continued)	Findings
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that all patient care areas and public restrooms are clean and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that procedures for terminal cleaning of patient rooms are followed and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that in patient care areas, damaged furniture is repaired or removed from service and damaged surfaces are repaired and that compliance be monitored.

9. We recommended that the pharmacy clean room for compounding sterile products be brought into compliance with United States Pharmacopeia <797> cleanliness, sterility, and monitoring standards.

10. We recommended that processes be strengthened to ensure that all required members of the Environment of Care Committee consistently attend committee meetings, that the program be strengthened to ensure effective surveillance activities, and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that VA Police update the facility's Security Management Plan annually and submit quarterly security reports to the Environment of Care Committee.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 19 patients who experienced stroke symptoms, and 15 employee training records (5 emergency department, 5 intensive care unit, and 5 acute inpatient unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, the intensive care unit, two acute inpatient units, and the mental health unit. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Four of the applicable 11 EHRs did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Fourteen of the applicable 15 EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• Seven of the applicable nine EHRs did not contain documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff involved in assessing and treating stroke patients.	
	The facility collected and reported required data related to stroke care.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy required that PTT and PT/INR tests be completed for patients presenting with stroke symptoms. • Eight of the applicable 10 EHRs did not contain documented evidence that PTT and/or PT/INR tests were completed.

Recommendations

12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

14. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that clinician assessment of patients presenting with stroke symptoms includes facility required PTT and PT/INR tests and that compliance be monitored.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[f]

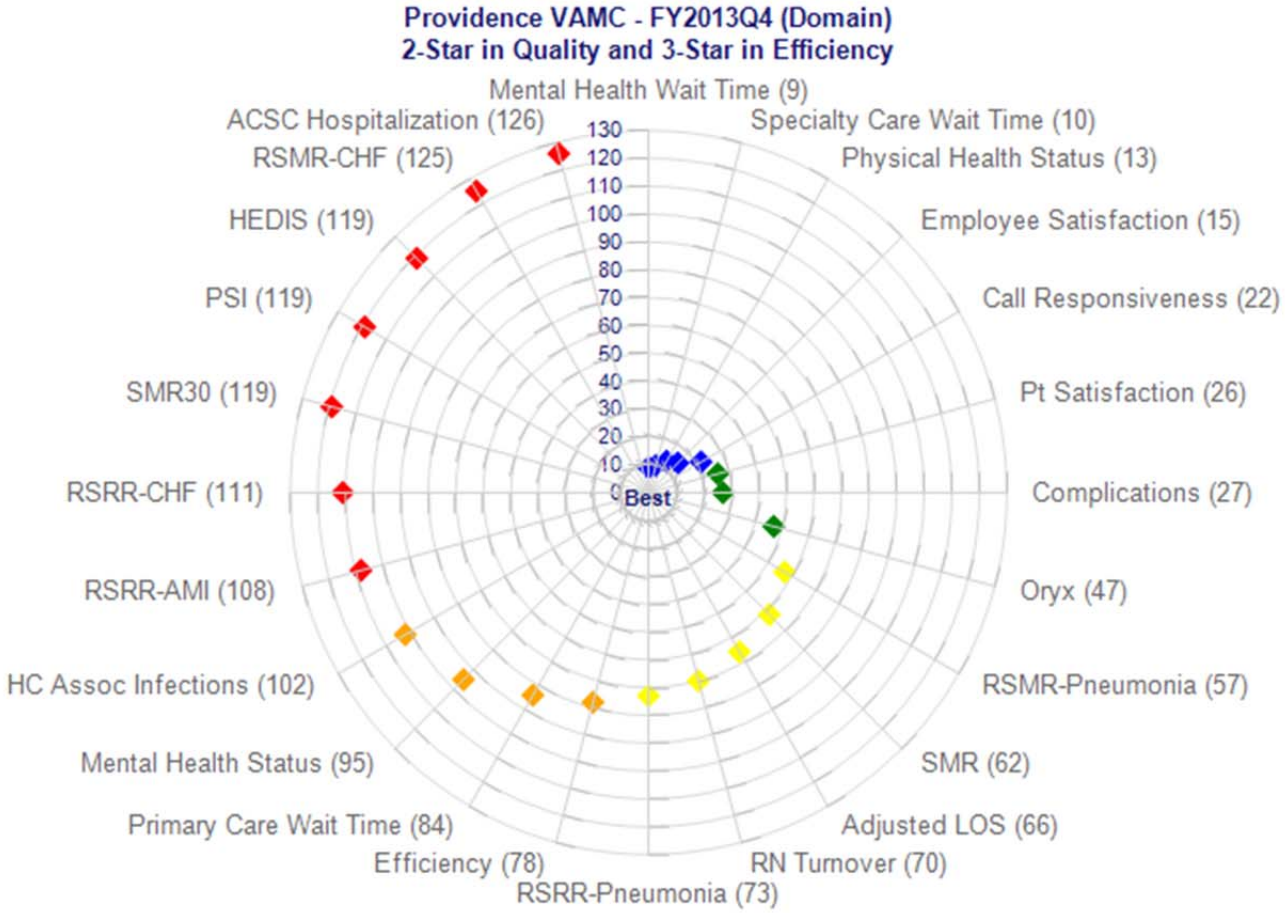
We reviewed relevant documents and the training records of 41 employees (30 randomly selected Level 1 ancillary staff and 11 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member or caregiver and reviewed and signed by a Level 2 MRI personnel.	
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Providence/650) FY 2014 through June 2014[2]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$225.9
Number of:	
• **Unique Patients**	29,833
• **Outpatient Visits**	273,789
• **Unique Employees**[3]	1,101
Type and Number of Operating Beds:	
• **Hospital**	73
• **Community Living Center**	NA
• **Mental Health**	18
Average Daily Census (as of May):	
• **Hospital**	50
• **Community Living Center**	NA
• **Mental Health**	14
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	New Bedford/650GA Hyannis/650GB Middletown/650GD
VISN Number	1

[2] All data is for FY 2014 through June 2014 except where noted.
[3] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

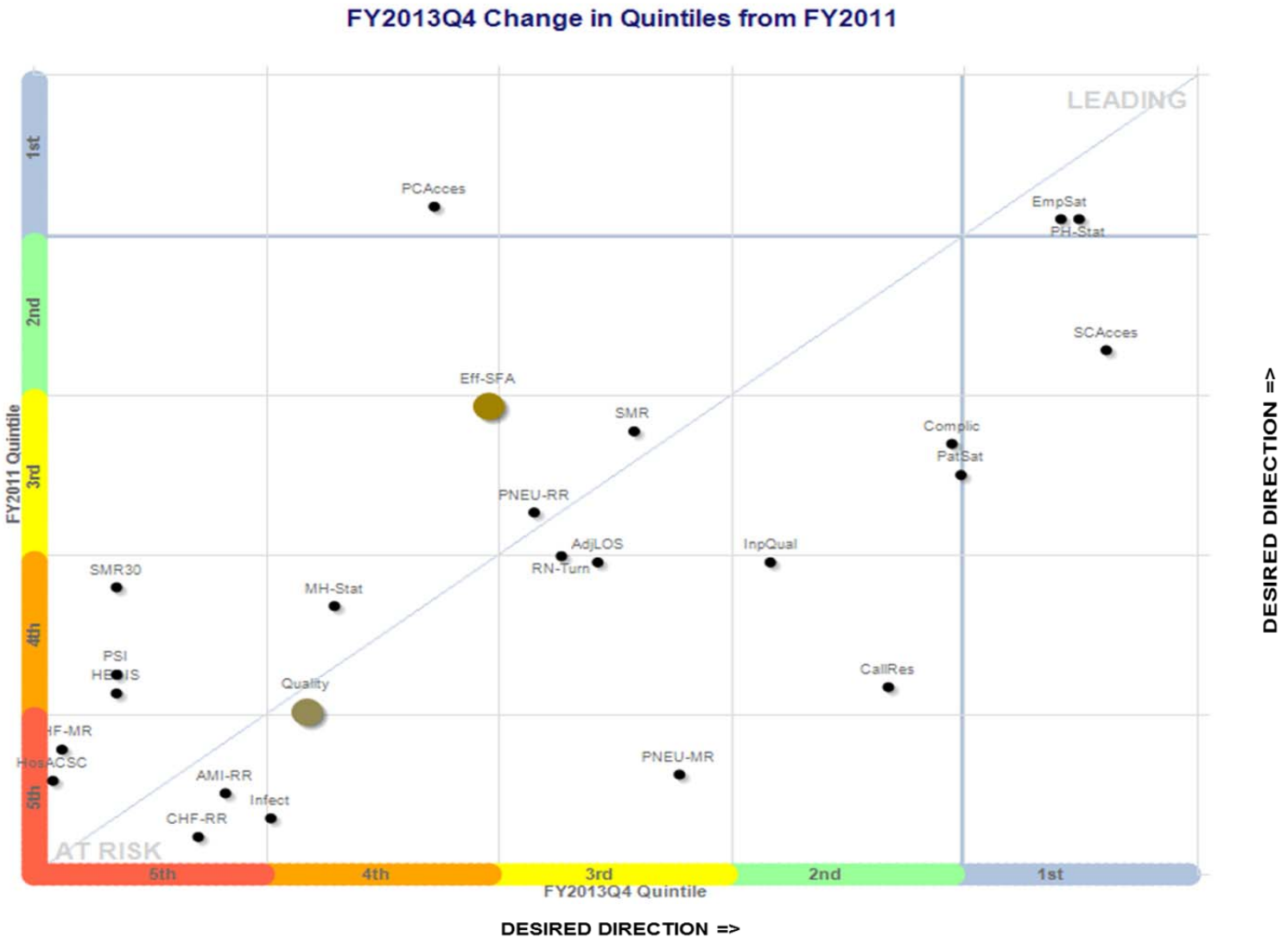
Strategic Analytics for Improvement and Learning (SAIL)[4]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[4] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 8, 2014

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

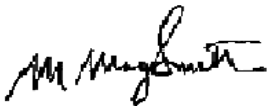
Subject: **CAP Review of the Providence VA Medical Center Providence, RI**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I have reviewed and concur with the action plans regarding the CAP Review of the Providence VA Medical Center, Providence, RI June 14, 2014.

Sincerely,



Michael F. Mayo-Smith, MD, MPH
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2014

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

Subject: **CAP Review of the Providence VA Medical Center Providence, RI**

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

I have reviewed and concur with the action plans regarding the CAP Review of the Providence VA Medical Center, Providence, RI June 14, 2014.

Sincerely,

Susan A. MacKenzie, PhD
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that completed actions from peer reviews are reported to the Peer Review Committee.

Concur

Target date for completion: November 1, 2014

Facility response: A plan to improve and revise the peer review process was implemented beginning in May 2014. When the Peer Review Committee assigns a Level 2 or Level 3, the committee through the Chief of Staff's office will send a letter to the service chief and request that an action plan be identified and implemented in collaboration with the provider involved. The Committee will track the level 2 and 3 action plan assignments through a facility developed tool. Once action is completed it will be reported back to the Peer Review Committee for closing. The process will be tracked until November 2014.

Recommendation 2. We recommended that processes be strengthened to ensure that the Special Care Committee collects data that measures performance in responding to codes.

Concur

Target date for completion: September 1, 2014.

Facility response: An interdisciplinary committee (Special Care Committee) is responsible for reviewing episodes of care where resuscitation was attempted. Beginning at the June meeting of the Special Care Committee, all codes were reviewed, brief discussion ensued and information included in the committee minutes. This information is tracked in a database and data aggregated over the course of the fiscal year.

Recommendation 3. We recommended that the Surgical Service Staff Committee meet monthly.

Concur

Target date for completion: October 1, 2014.

Facility response: The Surgical Work Group Committee has been retooled to better align with the directive requirements to meet monthly. Since May, 2014 the committee has met monthly and monthly meetings have been established going forward.

Recommendation 4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee meets at least quarterly and that the blood/transfusions usage review process includes the results of proficiency testing and the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: November 1, 2014.

Facility response: The Blood Usage Committee members have been reeducated regarding their responsibilities per committee policy. Quarterly meetings have been scheduled and the standard agenda includes all elements to be reviewed per policy. The proficiency testing report will now be included as an agenda item in the committee. Peer reviews results when transfusions do not meet criteria will also be reported at this committee though there have not been any occurrences this fiscal year.

Recommendation 5. We recommended that processes be strengthened to ensure that when data analysis indicates problems or opportunities for improvement, actions are consistently identified, implemented, and followed to resolution in surgical performance improvement activities, electronic health record quality reviews, and blood/transfusion reviews.

Concur

Target date for completion: November 1, 2014.

Facility response: As stated above in number 4. These committees have been reeducated regarding their responsibilities per their individual committee policies regarding any corrective actions to be implemented and the need to follow thru to completion and note in the respective minutes. The minutes for these committees will be monitored for three months to ensure compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that all patient care areas and public restrooms are clean and that compliance be monitored.

Concur

Target date for completion: December 1, 2014.

Facility response: A restoration contractor was hired in July, 2014 to bring all areas up to healthcare building standards of cleanliness. It is anticipated that the contract work will take up to 120 days. The hiring of twenty additional Housekeeping Aids has been authorized and recruitment is open and continuous. Restrooms are monitored hourly for cleanliness and a sign in sheet appears in each. Sheets will be retained and

summary provided to the EOC committee and Quality Management on a monthly basis. Also hiring progress to be monitored and updates presented at EOC committee.

The facility has begun the process of reorganizing Environmental Management Services out of FMS and will formalize EMS as an independent service with direct oversight by the Associate Director of Operations. Human Resources is in the process of formally separating out the service, creating levels of service leadership, support staff and training positions. The reorganization of EMS is expected to provide the facility with a strong emphasis on EOC oversight. Target date for completion is 150 days as recruitment will need to occur.

Recommendation 7. We recommended that processes be strengthened to ensure that procedures for terminal cleaning of patient rooms are followed and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: Supervisors will monitor all rooms following a terminal cleaning, document compliance and provide summary report monthly at EOC Committee and to Quality Management. A full time training position for Housekeeping Aids is being created and will be recruited for. A separate room is being set aside for training of housekeepers in terminal cleaning of patient rooms.

Recommendation 8. We recommended that processes be strengthened to ensure that in patient care areas, damaged furniture is repaired or removed from service and damaged surfaces are repaired and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: Damaged furniture has been replaced and damaged surfaces have been repaired. Clarification of process owner's responsibility to report damaged furniture and damaged wall surfaces has been established. Furniture is routinely inspected by EMS during cleaning and damaged furniture replaced. During EOC weekly rounds the EMS person will inspect the area being reviewed for any damaged furniture and damaged wall surfaces.

Recommendation 9. We recommended that the pharmacy clean room for compounding sterile products be brought into compliance with United States Pharmacopeia <797> cleanliness, sterility, and monitoring standards.

Concur

Target date for completion: February 1, 2015 for permanent <797> ISO 7 compliant room.

Facility response: The facility is preparing temporary locations for pharmacy's clean room operations while we await funding to build the approved permanent <797> fully compliant clean room for the Inpatient Pharmacy. In the interim, preparation of chemotherapy agents will be conducted in a <797> compliant IV trailer using certified negative pressure isolator (ISO 5). The sterile compounding of the other parenteral products will use a certified positive pressure isolator (ISO 5). This isolator is located in a separate and dedicated clean room. It is anticipated that the temporary facilities will be in use within 60 days followed by completion of the permanent facilities in February 2015. Environmental/biological testing and monitoring will commence upon awarding of a contract with an outside monitoring service.

Recommendation 10. We recommended that processes be strengthened to ensure that all required members of the Environment of Care Committee consistently attend committee meetings, that the program be strengthened to ensure effective surveillance activities, and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: Reestablished oversight by the Chief of Facility Management Service and the Associate Director is providing supervision and direction for the EOC Committee to ensure compliance with components of the Environment of Care Committee policy and Directives.

Recommendation 11. We recommended that processes be strengthened to ensure that VA Police update the facility's Security Management Plan annually and submit quarterly security reports to the Environment of Care Committee.

Concur

Target date for completion: November 1, 2014.

Facility response: Reestablished oversight by the Chief of Facility Management Service and the Associate Director is providing supervision and direction to ensure compliance with components of the Environment of Care Committee policy and Directives. The Security Management Plan will be reviewed and a standard report template for the Police Service was developed to report to the EOC Committee on a quarterly basis.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: The Clinicians were reeducated and they will be completing the stroke template. All records will be monitored for compliance and outcome reported at Stroke Committee and to Quality Management.

Recommendation 13. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: November 1, 2014.

Facility response: This requirement was added to the nursing stroke/TIA template which will facilitate capturing the information in a standardized mode. The standard operating procedure dysphagia screening was developed and accepted. All nursing personnel were educated by May 30, 2014. All records will be monitored for three months to ensure compliance.

Recommendation 14. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: This requirement was added to the nursing stroke/TIA assessment template to ensure compliance. All records will be monitored for three months to ensure compliance.

Recommendation 15. We recommended that processes be strengthened to ensure that clinician assessment of patients presenting with stroke symptoms includes facility required PTT and PT/INR tests and that compliance be monitored.

Concur

Target date for completion: November 1, 2014.

Facility response: The physician order set was edited to include PTT and all clinicians were reeducated. We will monitor for three months to ensure compliance.

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Endnotes

[a] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
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- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
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- Manufacturer's instructions for Cipro® and Levaquin®.
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[e] The references used for this topic were:
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- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

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- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
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- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
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