Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00886-210

Combined Assessment Program Review of the VA New Jersey Health Care System East Orange, New Jersey

June 13, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
CS	controlled substances
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	VA New Jersey Health Care System
FY	fiscal year
HPC	hospice and palliative care
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PD	position description
PT	physical therapy
QM	quality management
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 March 11, 2013.

Review Results: The review covered eight activities. We made no recommendations in the following activity:

- Construction Safety

The facility's reported accomplishments were the hospice and palliative care memorial tribute book, simulation and experiential education, and the Quiet Campaign.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Revise the local observation bed policy to include all required elements. Consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure clinicians perform and document patient assessments following blood product transfusions. Require that code evaluation sheets are completed for all code episodes and that code sheets are scanned into the electronic health records.

Environment of Care: Store clean and dirty items separately. Ensure sensitive patient information is secured on computer screens in the emergency department. Terminally clean medical equipment in the emergency department after patient discharge. Properly store supplies and equipment in the East Orange physical therapy clinic.

Medication Management – Controlled Substances Inspections: Amend facility policy to address that the Controlled Substances (CS) Coordinator position description or functional statement must include CS inspection and coordination, to include that the CS Coordinator must have complete understanding of CS policies and the Veterans Health Administration inspection process, and to include requirements for new CS inspector orientation and annual training thereafter. Ensure CS inspectors receive annual updates and/or refresher training.

Coordination of Care – Hospice and Palliative Care: Ensure all non-hospice and palliative care staff receive end-of-life training.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly. Require contracts for oxygen delivery to contain educational information on the hazards of smoking while oxygen is in use. Re-evaluate home oxygen program patients for home oxygen therapy annually after the first year. Ensure that home oxygen program patients deemed to be high risk have fire risk assessments completed and that 3-month follow-up evaluations are completed for all home oxygen program patients.

Nurse Staffing: Include all required members on unit 9A's expert panel. Require that the annual staffing plan reassessment process ensures that all required staff are facility expert panel members.

Preventable Pulmonary Embolism: Initiate protected peer review for the identified patient, and complete any recommended review actions.

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 20–28, for the full text of the Directors' comments.) We consider recommendations 8, 9, and 10 closed. We will follow up on the planned actions for the open recommendations 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

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction 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 and FY 2013 through March 15, 2013, 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 VA New Jersey Health Care System, East Orange, New Jersey,* Report No. 10-00470-172, June 15, 2010).

During this review, we presented crime awareness briefings for 323 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 590 responded. We shared survey 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

HPC Memorial Tribute Book

The HPC team provides veterans with a copy of the book, *One Who Served: A Memorial Tribute to Your Veteran*, a record of the veteran's life and experiences. Staff encourage veterans admitted to HPC to work with their family and friends to fill the pages of the book. The book then serves as a memorial and tribute to the veteran and a keepsake for family and friends.

Simulation and Experiential Education

To enhance patient care through staff education, the facility constructed two contemporary and flexible full-scale inpatient and outpatient simulation rooms that incorporate features of evidence-based design, patient-centered care principles, and learning spaces. These rooms provide a staff education resource that enhances the ability to simulate inpatient or outpatient environments. This experientially based learning environment supports staff training in traditional and less common patient care scenarios.

Quiet Campaign

The Quiet Campaign was implemented to reduce noise volume on an inpatient medical unit. The campaign includes the use of sound monitors that provide visible noise volume alerts, signage that includes photographs of facility staff, a quiet hour, therapeutic music, and aromatherapy. Telephone rings were lowered, and door hinges were padded to avoid slamming. These modifications have contributed to marked improvement in patient satisfaction.

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 complied with selected requirements within its QM program.[1]

We interviewed 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 NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include that each observation patient must have a focused goal for the period of observation or that each admission must have a limited severity of illness. Additionally, the policy did not include the process for determining the admitting physician.
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	

NC	Areas Reviewed (continued)	Findings
	There was an EHR quality review committee, and the review process complied with selected requirements.	
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-nine EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Five test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Thirty-three EHRs of patients who received blood products reviewed: • There was no documentation in 12 EHRs (36 percent) that the outcome was assessed.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that 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.	
X	The facility complied with any additional elements required by VHA or local policy.	Twelve months of CPR episodes of care reviewed: • Evaluation sheets were not completed for 6 of 33 (18 percent) CPR codes as required by local policy. • Five spot-checked EHRs did not contain scanned code sheets as required by local policy.

Recommendations

1. We recommended that the local observation bed policy be revised to include all required elements.

2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

3. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

4. We recommended that processes be strengthened to ensure that code evaluation sheets are completed for all code episodes and that code sheets are scanned into the EHRs.

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.[2]

At the East Orange campus, we inspected one medical/surgical unit, the acute MH unit, one intensive care unit, the ED, the PT clinic, and the women's health clinic. At the Lyons campus, we inspected one acute MH unit, one CLC unit, and the PT and occupational therapy clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	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.	
	The facility had a policy that detailed cleaning of equipment between patients.	
X	Patient care areas were clean.	• In three of the six units/areas inspected, clean and dirty items were not stored separately.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
X	Sensitive patient information was protected, and patient privacy requirements were met.	• In the ED, sensitive patient information on computer screens was not blocked from public view.
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on cleaning and disinfection of non-critical reusable medical equipment and patient care items reviewed: • ED staff did not consistently perform terminal cleaning of intravenous pumps and poles and bedrails after patient discharges.

NC	Areas Reviewed for the Women's Health Clinic	Findings
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• In the East Orange PT clinic, new supplies were stored inappropriately under a treatment table, and dirty and clean equipment were not stored separately.
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

6. We recommended that processes be strengthened to ensure that sensitive patient information is secured on computer screens in the ED.

7. We recommended that processes be strengthened to ensure that medical equipment in the ED is terminally cleaned after patient discharge.

8. We recommended that processes be strengthened to ensure that supplies and equipment in the East Orange PT clinic are properly stored.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	Facility policy was consistent with VHA requirements.	Facility CS inspection policy reviewed. Policy did not: • Address that the CS Coordinator PD or functional statement must include CS inspection and coordination. • Include that the CS Coordinator must have complete understanding of CS policies and the VHA inspection process. • Include requirements for new CS inspector orientation and annual training thereafter.
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator PD(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	• CS inspectors did not receive annual updates and/or refresher training.
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

9. We recommended that facility policy be amended to address that the CS Coordinator PD or functional statement must include CS inspection and coordination, to include that the CS Coordinator must have complete understanding of CS policies and the VHA inspection process, and to include requirements for new CS inspector orientation and annual training thereafter.

10. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• Of the 15 non-HPC staff, there was no evidence that 7 had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

11. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 34 EHRs of patients enrolled in the home oxygen program (including 9 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
	The facility had established a home respiratory care team.	
X	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	One contract reviewed: • Educational information on the hazards of smoking while oxygen is in use was not incorporated in the contract.
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Eighteen (56 percent) of 32 EHRs contained no documentation of a re-evaluation after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policies reviewed: • Of the 9 patients identified as smokers, there were a total of 26 initial evaluations and/or re-evaluations for home oxygen. Eight of these evaluations did not have a fire risk assessment in accordance with local policy. • Twenty-seven (79 percent) of the 34 EHRs did not have documentation of a 3-month follow-up evaluation in accordance with local policy.

Recommendations

12. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

13. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain educational information on the hazards of smoking while oxygen is in use.

14. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

15. We recommended that processes be strengthened to ensure that home oxygen program patients deemed to be high risk have fire risk assessments completed and that 3-month follow-up evaluations are completed for all home oxygen program patients.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).

We reviewed relevant documents and 14 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit (East Orange) 9A and CLC unit (Lyons) LNH 2B for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	The unit-based expert panels followed the required processes.	• Unit 9A's panel did not include any licensed practical nurses.
X	The facility expert panel followed the required processes and included all required members.	• The facility panel did not include staff nurses or other nursing staff providing direct patient care, evening and night supervisory staff, nurse managers from the various areas of the facility, or the labor partner representative.
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

16. We recommended that unit 9A's expert panel include all required members.

17. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[6]

We reviewed relevant documents and 12 EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	• One patient was identified as having a potentially preventable pulmonary embolism because the patient had risk factors and had not been provided anticoagulation medication.
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

Recommendation

18. We recommended that managers initiate protected peer review for the identified patient and complete any recommended review actions.

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected the Ward 5 upgrade project. Additionally, we reviewed relevant documents and 10 training records (5 contractor records and 5 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Facility Profile (East Orange/561) FY 2012	
Type of Organization	Health care system
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$486
Number of: • **Unique Patients**	58,915
• **Outpatient Visits**	715,544
• **Unique Employees**[b]	1,986
Type and Number of Operating Beds: • **Hospital**	93
• **CLC**	245
• **MH**	248
Average Daily Census: • **Hospital**	58.5
• **CLC**	214.1
• **MH**	213.9
Number of Community Based Outpatient Clinics	11
Location(s)/Station Number(s)	Lyons/561A4 Brick/561BZ Hamilton/561GA Elizabeth/561GB Hackensack/561GD Jersey City/561GE Piscataway/561GF Newark/561GG Morristown/561GH Tinton Falls/561GI Paterson/561GJ
VISN Number	3

[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		**Outpatient Scores**			
	FY 2012		**FY 2012**			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	54.6	64.8	56.9	59.2	52.6	62.5
VISN	60.2	62.9	58.6	57.9	58.2	59.0
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	**	11.8	13.7	**	27.0	20.6
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[c] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2013

From: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Subject: **CAP Review of the VA New Jersey Health Care System, East Orange, NJ**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

I have reviewed the OIG Combined Assessment Program (CAP) Review for the VA New Jersey Health Care System. I concur with the responses submitted from the VANJHCS Director, Mr. Kenneth H. Mizrach.

If you have any questions or require additional information, please contact Pam Wright, RN MSN, VISN3 QMO, at 718-741-4143.

Michael A. Sabo, FACHE
VISN 3 Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 24, 2013

From: Director, VA New Jersey Health Care System (561/00)

Subject: **CAP Review of the VA New Jersey Health Care System, East Orange, NJ**

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

Thank you for the opportunity to review the draft report of the OIG Combined Assessment Program (CAP) Review for our VA New Jersey Health Care System. I have reviewed the document and concur with the recommendations noted.

The VA New Jersey Health Care System has established corrective action plans with designated dates of completion, as detailed in the attached report. If additional information or assistance is needed, please do not hesitate to contact our Lead Accreditation Specialist, Pamela J Brooks RN-BC, at 973 676 1000, x1215.

KENNETH H. MIZRACH
Director, VANJHCS

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 the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: June 2013

Facility response: The current VANJHCS MCM # CC-07, entitled Observation Policy, will be reviewed and revised to include all required elements in VHA Directive 2010-011.

Recommendation 2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: August 2013

Facility response: The VANJHCS acknowledges the importance of strengthening appropriate quality control processes to ensure the timely scanning of non-VA purchased diagnostic care in the electronic health record (EHR). A workgroup led by the Business Office, Fee Basis Care will review, revise, and monitor these processes as appropriate to ensure that the diagnostic test results of patients who receive non-VA purchased care are scanned into the EHR. The results of monitoring will be reported quarterly at the Medical Records Committee.

Recommendation 3. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

Concur

Target date for completion: August 2013

Facility response: The VANJHCS acknowledges the importance of accurately performing and documenting patient assessments following blood product transfusions in the electronic health record (EHR). The VANJHCS Transfusion Committee will review and revise their current monitor to include evidence of clinician documentation of patient assessments following blood product transfusions, as noted per VHA Directive. The results of monitoring will be reported at Transfusion Committee, and quarterly to the Medical Records Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that code evaluation sheets are completed for all code episodes and that code sheets are scanned into the EHRs.

Concur

Target date for completion: August 2013

Facility response: The VANJHCS acknowledges the importance of strengthening appropriate quality control processes to ensure that code evaluation sheets are completed for all code episodes and the timely scanning of code sheets into the electronic health record (EHR). A workgroup led by the Chairperson of the CPR Committee will review, revise, and monitor these processes to ensure the timely completion of all code episode evaluation and that the paper code sheets are scanned into the EHR. The results of monitoring will be reported at CPR Committee and rolled up quarterly to the Medical Records Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

Concur

Target date for completion: June 2013

Facility response: Unit and Clinic Managers removed all items inappropriately stored and enforced the processes for the separation of clean and dirty storage with frontline staff. IP&C Staff will inservice frontline staff to re-enforce this, and provide immediate feedback to frontline staff during EOC Rounds to ensure sustained compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that sensitive patient information is secured on computer screens in the ED.

Concur

Target date for completion: May 2013

Facility response: The VANJHCS acknowledges the importance of protecting sensitive patient information and patient privacy in the Emergency Department. The ED Chief will work with the Information Security Officer to ensure sensitive patient information displayed on computer screens are protected and blocked from public view in the ED by the installation of privacy screens.

Recommendation 7. We recommended that processes be strengthened to ensure that medical equipment in the ED is terminally cleaned after patient discharge.

Concur

Target date for completion: June 2013

Facility response: The VANJHCS acknowledges the importance of ensuring that medical equipment in the ED is appropriately cleaned after patient discharge. The ED Chief and Nurse Manager along with IP&C Staff will inservice the ED Staff and the Housekeeping Staff on the current VANJHCS MCM # IC-31, entitled "Cleaning and Disinfection of Non-Critical Reuseable Medical Equipment (RME) and Patient Care items (PCI)" to strengthen and ensure compliance with VANJHCS local policy, and VHA requirements. The Chief of Guest Relations Services will assign housekeeping staff to the ED to ensure cleaning after patient discharge is completed. A cleaning schedule for the RME and patient care items was initiated with the Housekeeping Staff and ED Staff.

Recommendation 8. We recommended that processes be strengthened to ensure that supplies and equipment in the East Orange PT clinic are properly stored.

Concur

Target date for completion: April 2013 (completed)

Facility response: The VANJHCS acknowledges the importance of strengthening processes to ensure that supplies and equipment in the East Orange PT Clinic are stored properly. The Chief of PM&R Service has inserviced the PT staff on the current VANJHCS MCM # IC-31, entitled "Cleaning and Disinfection of Non-Critical Reuseable Medical Equipment (RME) and Patient Care items (PCI)" to strengthen and ensure compliance with VANJHCS local policy, and VHA requirements. A cleaning schedule for the PT area was initiated with the housekeeping staff and a cleaning schedule for reuseable patient care items such as canes, crutches, exercise-bands was initiated with the PT staff. Storage bins were set up to facilitate compliance with proper storage of supplies and equipment. The entire PM&R Service is scheduled to move into their newly renovated space in June 2013, which will provide proper storage and space to ensure sustained compliance.

Recommendation 9. We recommended that facility policy be amended to address that the CS Coordinator PD or functional statement must include CS inspection and coordination, to include that the CS Coordinator must have complete understanding of CS policies and VHA inspection process, and to include requirements for new CS inspector orientation and annual training thereafter.

Concur

Target date for completion: March 2013 (completed)

Facility response: The current VANJHCS MCM # MM-16, entitled Controlled Substance Inspection (CSI) Program, was reviewed and amended during the on-site OIG CAP Review to address the CS Coordinator's functional statement, including CS inspection and coordination, and the CS Coordinator's competencies noting an understanding of CS Policies, VHA inspection process, and CS Inspector orientation & annual training. OIG CAP Team Members reviewed these revisions while on-site and found the policy compliant. This midcycle revision of VANJHCS MCM # MM-16 was published on the VANJHCS webpage for 24 / 7 access by all employees on March 15, 2013.

Recommendation 10. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

Concur

Target date for completion: March 2013 (completed)

Facility response: The VANJHCS acknowledges the importance of strengthening the processes to ensure that CS Inspectors receive annual training and/or refresher training. The current VANJHCS MCM # MM-16, entitled Controlled Substance Inspection (CSI) Program, was reviewed and amended during the on-site OIG CAP Review to include the requirement for CS Inspectors to receive annual updates and/or refresher training. The CS Coordinator provided the OIG CAP Team Members with a draft copy of a quarterly CSI Program Newsletter that will be utilized as a refresher training to ensure CS Inspector annual training is completed. OIG CAP Team Members reviewed this draft and found this to be compliant as a mechanism to update and in-service CS Inspectors. The CS Coordinator finalized the CSI Program newsletter and sent it to all CS Inspectors via outlook on March 14, 2013; the CS Coordinator will continue this process as a quarterly CSI Program Newsletter.

Recommendation 11. We recommended that processes be strengthened to ensure that all non-HPC staff receive end-of-life training.

Concur

Target date for completion: August 2013

Facility response: The VANJHCS acknowledges the importance of strengthening the process to ensure that non-HPC staff received end-of-life training. The PCCT Coordinator along with assistance from the HPC Provider, PCCT, PCS Education, and other Services will ensure that all non-HPC staff receive end-of life training. The PCCT Coordinator will utilize the TMS/HEN on-line module education, in order to reach the non-HPC staff within the organization and will confirm training via documented TMS course completion.

Recommendation 12. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur

Target date for completion: November 2013

Facility response: The VANJHCS and the Home Respiratory Care Program acknowledge the importance of demonstrating that the VANJHCS Chief of Staff reviews the programs activities quarterly. The VANJHCS Pulmonologist, along with the Home Respiratory Care Team (HRCT), will ensure that the Chief of Staff (COS) is provided the opportunity to review the activities of the Home Respiratory Care Program quarterly, via

providing HRCT meeting minutes and regular reporting to the Executive Committee of the Medical Staff (ECMS). The VANJHCS Pulmonologist provided the first report to the COS and the ECMS on April 19, 2013; and this will continue quarterly.

Recommendation 13. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain educational information on the hazards of smoking while oxygen is in use.

Concur

Target date for completion: Pending Contract Approval (VISN)

Facility response: The VANJHCS acknowledges the importance of strengthening the contracts for delivery of home oxygen therapy to ensure they contain educational information on the hazards of smoking while on oxygen. VISN 3 Contracting Officer along with the COR for Home Oxygen Therapy have revised the contracts for home oxygen therapy to incorporate the requirement for providing educational information on the hazards of smoking while oxygen is in use.

Recommendation 14. We recommended that processes be strengthened to ensure that home oxygen program patients are re-evaluated for home oxygen therapy annually after the first year.

Concur

Target date for completion: August 2013

Facility response: The VANJHCS acknowledges the importance of strengthening the processes to ensure home oxygen program patients are re-evaluated annually after the first year. The VANJHCS Pulmonologist along with the Home Respiratory Care Team (HRCT) will ensure that all home oxygen patients have an annual re-evaluation for home oxygen therapy completed. The HRCT is currently scheduling patients for their annual evaluations. This will be tracked by the HRCT and reported at their meetings; the VANJHCS Pulmonologist will roll this up with his quarterly COS reports.

Recommendation 15. We recommended that processes be strengthened to ensure that home oxygen program patients deemed to be high risk have fire risk assessments completed and that 3-month follow-up evaluations are completed for all home oxygen program patients.

Concur

Target date for completion: September 2013

Facility response: The VANJHCS acknowledges the importance of strengthening the fire risk assessments for home oxygen program patient who deemed to be high risk and the importance of ensuring that 3-month follow-up are completed for all home oxygen patients. The VANJHCS Pulmonologist along with the Home Respiratory Care Team

(HRCT) will ensure that all high risk patients have a fire risk assessment completed. This will be demonstrated by the completion of the consult entitled “Prosthetics Request IFC Home O2 VISN3” for all initial, renewal, or change in Home Oxygen Prescription. In addition the iMED agreement entitled “Smoking and Oxygen Hazard Awareness: Home Safety Agreement” is also completed. The VANJHCS Pulmonologist along with the Home Respiratory Care Team (HRCT) will ensure that all home oxygen program patients have a 3-month follow-up evaluation completed. This will be monitored by the VANJHCS Pulmonologist along with the Home Respiratory Care Team (HRCT) and will be included in their HRCT meeting minutes which are provided to the COS quarterly.

Recommendation 16. We recommended that unit 9A’s expert panel include all required members.

Concur

Target date for completion: June 2013

Facility response: The VANJHCS acknowledges the importance of ensuring that our unit-based expert panel include all the required members. The Associate Director of Patient Care Services along with the Director of Clinical Services and Unit 9A Nurse Manager are revising Unit 9A’s unit-based expert panel to include Licensed Practical Nurses. The new LPN member will be a participating member starting with the next nurse staff methodology expert panel meeting for Unit 9A on May 20, 2013.

Recommendation 17. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

Concur

Target date for completion: July 2013

Facility response: The VANJHCS acknowledges the importance of ensuring that the organization’s expert panel includes all the required members. The Associate Director of Patient Care Services along with the Directors of Clinical Services are revising the VANJHCS expert panel to ensure representation from staff nurses or other nursing staff providing direct patient care, evening and night supervisory staff, nurse mangers from various areas of the organization, and/or the labor partner representative. This representation will start at the next nurse staff methodology expert panel meeting scheduled for June 2013.

Recommendation 18. We recommended that managers initiate protected peer review for the identified patient and complete any recommended review actions.

Concur

Target date for completion: July 2013

Facility response: The VANJHCS Chief of Staff and Director of Quality Management acknowledge the importance of providing the appropriate care to patients who are at risk of developing preventable pulmonary embolism. This was sent for a protected peer review of the care provided to the patient.

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Endnotes

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[7] References used for this topic included:
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