Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02385-62

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

January 13, 2011

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

AAMI	Association for the Advancement of Medical Instrumentation
ANSI	American National Standards Institute
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
EOC	environment of care
facility	Philadelphia VA Medical Center
FY	fiscal year
GU	genitourinary
IC	infection control
MH	mental health
MRI	magnetic resonance imaging
MSIT	Multidisciplinary Safety Inspection Team
NFPA	National Fire Protection Association
NUMI	National Utilization Management Integration
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
PR	peer review
QM	quality management
RME	reusable medical equipment
SBAR	Situation, Background, Assessment, Recommendation
SHEP	Survey of Healthcare Experiences of Patients
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Philadelphia VA Medical Center, Philadelphia, PA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 13, 2010.

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

- Coordination of Care
- Medication Management
- Suicide Prevention Safety Plans

The facility's reported accomplishments were resident memorials and the use of a Behavioral Health Laboratory model.

Recommendations: We made recommendations in the following five activities:

Quality Management: Document action plans in committee minutes, request peer review extensions in writing, comply with policy for reporting patient complaint data, and monitor the copy and paste functions.

Physician Credentialing and Privileging: Comply with requirements for physician privileging.

Reusable Medical Equipment: Restrict access to decontamination areas; ensure staff don personal protective equipment; and conduct required ventilation, air filter, and air exchange inspections. Require that standard operating procedures be consistent with manufacturers' guidelines and be followed. Ensure flash sterilization is used in the operating room only in case of emergency, and continue monitoring.

Environment of Care: Address the identified environmental hazard. Conduct a self-assessment, and take corrective actions as necessary. Require consistent documentation of biological testing. Ensure designated staff undergo required annual training. Ensure that rounds are attended and that attendance is documented.

Magnetic Resonance Imaging Safety: Ensure personnel address positive responses on screening questionnaires and document actions taken. Require referring physicians to document initial screenings. Ensure that personnel who have access to the area receive the appropriate level of safety training and that training is documented.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Objectives and Scope

Objectives

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide 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

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- EOC
- Medication Management
- MRI Safety
- QM
- Physician C&P
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through September 13, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the Philadelphia VA Medical Center, Philadelphia, Pennsylvania,* Report No. 07-02498-52, January 4, 2008). We identified repeat findings from our prior review in the areas of QM committee minutes and EOC rounds attendance.

During this review, we also presented crime awareness briefings for 295 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

CLC Resident Memorials

Both individual bedside remembrances at the time of a resident's death and quarterly memorial services are held in the CLC to celebrate the lives of the deceased, to recognize their accomplishments, and to honor their death with dignity. The bedside remembrance service includes draping an American flag across the bed, playing peaceful music, and reciting the poem, *Taps*. Staff and other residents sign a sympathy card that is presented to the family. The memorials allow family, staff, and other CLC residents the opportunity to share in the bereavement process and to create positive, lasting memories.

Behavioral Health Lab

The facility developed a model of collaborative care management for veterans with MH issues that is consistent with the guiding principles of the Patient-Centered Medical Home. The program maximizes the use of nursing, psychology, or social work staff as care managers while retaining the primary care provider at the center of treatment planning. The model uses a well-structured screening tool; flexible, patient-centered service delivery; evidence-based care management protocols; and time-limited interventions. The program has been successful in improving patient outcomes in specific areas, increasing access, providing collaborative assistance to primary care practitioners to manage mild to moderate cases, and facilitating specialty care referral. The program was recently recognized by the American Psychiatric Association as a national best practice.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement and through the allocation of resources to the program. However, we identified the following areas that needed improvement.

QM Committee and Oversight. VHA requires that the QM program identify opportunities for improvement, implement actions, and evaluate those actions until problems are resolved or improvements are achieved.[1] We found that committee minutes did not consistently identify action plans. For example, Medical Executive Committee minutes stated that non-disposable tonometers should be replaced without identifying an action plan to provide for disposable ones.[2] This is a repeat finding from our previous CAP review. In addition, committee minutes did not consistently assign responsibility, track open action items, and monitor implemented changes. For example, Quality Council minutes inappropriately closed items requiring follow-up.

PR. VHA policy requires facilities to complete a PR within 120 days.[3] Any extension beyond 120 days must be requested in writing and approved by the facility's Director. We found that 10 (8 percent) of 118 PRs exceeded 120 days without evidence of the required written request and approval for extension.

Patient Complaints. VHA policy requires that facilities report patient complaint data quarterly to leadership.[4] We found that local policy requires biannual reporting and is not consistent with VHA policy.

Medical Record Review. Since 2006, VHA has required that facilities have a process for monitoring the copy and paste

[1] VHA Directive 2009-043, *Quality Management Systems*, September 11, 2009.
[2] A tonometer is an instrument for measuring tension or pressure, particularly pressure within the eye.
[3] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[4] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

functions in the electronic medical record.[5] We identified that the facility's policy was not effective until June 2010, and no monitoring took place during FY 2010 through September 13, 2010.

Recommendations

1. We recommended that committee minutes identify action plans, assign responsibility, track open action items, and monitor implemented changes.

2. We recommended that PR extensions be requested in writing and approved by the facility's Director.

3. We recommended that reporting of patient complaint data comply with VHA policy.

4. We recommended that the facility monitor the copy and paste functions in the electronic medical record.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles. We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for the one physician hired within the past 12 months. However, we identified the following areas that needed improvement.

Professional Practice Evaluation. VHA policy and external accrediting bodies require a written plan with specific competency criteria for all privileged physicians.[6] We found that the facility had defined privilege-specific criteria for the new providers and providers undergoing reprivileging. However, we reviewed 6 month's worth of data to confirm privilege-specific competencies and found insufficient OPPE information for seven of the nine applicable providers. In addition, we found that Credentialing Subcommittee of the Medical Executive Committee meeting minutes did not reflect discussion of physicians' performance data.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Physician Privileges. VHA requires that privileges be specific to the care setting, such as hospital or clinic.[7] We found that privileges were setting specific in only 2 (13 percent) of the 15 C&P files reviewed. For example, a surgeon was inappropriately granted privileges to perform complex surgery in the outpatient clinics as well as in the OR.

Recommendation

5. We recommended that all physicians' profiles include sufficient OPPE data and that privileges appropriately indicate the setting where they may be practiced.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining a safe environment. The facility's SPD and satellite reprocessing areas are required to meet VHA, AAMI, OSHA, and TJC's standards.

We inspected the anesthesia, cardiology, ear-nose-throat, gastrointestinal, GU, OR, radiology/ultrasound, and SPD reprocessing areas. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. Most employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies were current and consistently documented. During our tour of the anesthesia decontamination area, we noted that the SOPs were not located in the area where reprocessing occurred. This was corrected while we were onsite; therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

Radiology/Ultrasound Decontamination. VA policy requires that traffic in decontamination areas be restricted to authorized personnel.[8] We found that the reprocessing of ultrasound probes in radiology/ultrasound occurred in a patient area. The facility self-identified the problem and developed an action plan to relocate the reprocessing of

[7] VHA Handbook 1100.19.
[8] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.

ultrasound probes in order to restrict access to authorized personnel.

PPE. VA requires that staff wear PPE at all times while in decontamination areas.[9] PPE required in this area includes gown, gloves, shoe covers, and face mask. We observed individuals without appropriate PPE in the radiology/ultrasound and GU decontamination areas.

Ventilation and Airflow. VA requires that Engineering Service inspect the ventilation system and air filters at least quarterly.[10] Facility managers were unable to provide documentation of inspections of ventilation systems and air filters prior to July 2010 for any of the reprocessing areas other than SPD and the OR.

Additionally, for IC purposes, VA policy requires the use of negative ventilation and six air exchanges per hour in decontamination areas and the use of positive ventilation in clean areas. We found that the GU and radiology/ultrasound decontamination areas did not have six air exchanges per hour and were not under negative pressure. The GU and radiology/ultrasound clean areas were not under positive pressure. The facility had identified these deficiencies and had plans to relocate both the GU and radiology/ultrasound reprocessing to areas with proper ventilation.

SOPs. VHA requires SOPs for all pieces of RME to be current and consistent with manufacturers' guidelines.[11] We reviewed the SOP for stainless steel dental instruments and found that it was not consistent with the manufacturer's guidelines. Additionally, although the SOP for the colonoscope was current and consistent with the manufacturer's guidelines, during our observation of the cleaning, we found that the employee did not follow the procedural steps indicated by the SOP.

Flash Sterilization. VA requires full sterilization procedures to be used for all surgical instruments.[12] Flash sterilization (a shorter sterilization process) is to be used during a surgical procedure only in case of emergency, such as a dropped sterilized instrument. We reviewed 6 months of OR flash

[9] VA Handbook 7176.
[10] VA Handbook 7176.
[11] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[12] VA Handbook 7176.

sterilization log documentation and found that flash sterilization was used in non-emergent situations. The facility self-identified the increased use of flash sterilization and recently changed their process to address the issue.

Recommendations

6. We recommended that decontamination areas be restricted to authorized personnel.

7. We recommended that staff wear appropriate PPE in decontamination areas.

8. We recommended that ventilation system, air filter, and air exchange inspections be completed in accordance with VA policy.

9. We recommended that SOPs for all pieces of RME be consistent with the manufacturers' guidelines and that staff follow the procedural steps in the SOPs.

10. We recommended that flash sterilization be used in the OR only in case of emergency and that ongoing monitoring of flash sterilization be continued.

EOC

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, NFPA, and TJC's standards.

We inspected selected inpatient (medical/surgical, medical intensive care, MH, CLC) units, three outpatient (women's health, specialty, and primary care) clinics, the emergency department, the hemodialysis unit, the outpatient pharmacy, and all construction sites in the clinical areas. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Safety. Reduction of environmental factors that may contribute to suicide attempts and other self-injurious behaviors is a high priority in VA locked behavioral health units. In the bathrooms of three patient rooms on two different locked units, we found paper towel and trash cabinets with unlocked metal doors that could be used as anchor points. While we were onsite, the facility devised a

plan to address the hazard temporarily while pursuing options for a more permanent solution.

VHA policy requires that eyewash stations and/or showers be provided for emergency use in work areas where exposure to corrosive materials, blood, potentially infectious materials, and specified chemicals may occur.[13] All emergency eyewash stations must provide tepid water and be in unobstructed, accessible locations. Supervisors and employees must undergo appropriate training in the operation, use, and inspection of the eyewash station. We found one high-risk area that did not have an eyewash station, one eyewash station that staff were unable to demonstrate provided a safe water temperature, and one eyewash station that was not readily accessible to staff. Additionally, staff informed us that they had not received training in the use and operation of the eyewash stations that were present.

Patients with certain infectious diseases are placed in negative pressure rooms to help control the spread of certain airborne pathogens. When the negative pressure room is occupied, the Centers for Disease Control and Prevention require daily testing and documentation of the room's ventilation system. The facility did not have a process in place for the daily testing and documentation of negative pressure room ventilation systems.

TJC requires that medications be stored appropriately, that stored medications be labeled with expiration dates, and that drugs be removed promptly upon expiration. On one unit, we found insulin vials stored inappropriately and one opened vial of insulin without an expiration date. On another unit, we found two expired vials of insulin stored in the medication refrigerator.

Dialysis Unit. The ANSI and the AAMI require monthly biological testing of water and dialysate used for dialysis.[14] We reviewed 12 months of culture reports and found that staff documentation of biological testing was inconsistent.

Training. IC guidelines and local policy require that certain categories of staff undergo annual OSHA Bloodborne Pathogen Rule training. We found that only 17 (74 percent)

[13] VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
[14] Solution used to remove waste products from the blood during dialysis.

of 23 applicable staff records reviewed showed evidence of bloodborne pathogens training.

VHA policy requires that staff who work on locked inpatient MH units and members of the MSIT undergo initial and annual training on environmental hazards that represent a threat to suicidal patients.[15] Documentation of annual MH environmental hazards training was incomplete for the five MH unit employees and five MSIT members whose records we reviewed.

OSHA requires that staff identified to wear an N95 respirator undergo initial and annual fit testing and training. Only 1 (5 percent) of the 20 records reviewed of staff who worked in areas at high risk for exposure to airborne pathogens contained documentation of current testing and training.

CBOC Rounds. In the previous CAP report, we recommended that all designated EOC team members participate in all EOC rounds, that all CBOCs be inspected semi-annually, and that documentation of EOC rounds be complete. We found that CBOCs were inspected semi-annually and that documentation of EOC rounds was complete; however, documentation showed that on average, only 55 percent of team members or their designees participated in all EOC rounds. The EOC rounds attendance issue is a repeat finding.

Recommendations

11. We recommended that the facility develop a plan of action to address the environmental hazard on the locked MH units that represents a threat to suicidal patients.

12. We recommended that a self-assessment be conducted to ensure that issues with storage and labeling of medications, eyewash stations, and negative pressure rooms are identified throughout the facility and that corrective actions be taken as necessary.

13. We recommended that dialysis staff consistently document biological testing.

14. We recommended that designated staff undergo annual OSHA Bloodborne Pathogen Rule training, locked MH unit environmental hazards training, and fit testing and training.

[15] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist" memorandum, August 27, 2007.

15. We recommended that all EOC team members or their designees attend all EOC rounds and that attendance be documented.

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care. VA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.[16]

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment as required by TJC.

We found appropriate signage. We noted that patients were directly observed during MRIs. Two-way communication was available between the patient and the MRI technologist, and patients had access to a call system while in the scanner. Additionally, mock fire and emergency response drills had been conducted in the MRI area. We identified the following areas that needed improvement.

Safety Screening. VA and the American College of Radiology require screening of patients undergoing MRI. MRI technologists are required to review and sign the questionnaires and address any positive responses before a patient is scanned. A positive response on the questionnaire, such as an implanted device, must be addressed before a patient is scanned. We found complete documentation of technologist screenings in 7 (70 percent) of the 10 patient records that we reviewed.

Local policy requires the referring physician to complete an initial screening of the patient at the time the procedure is ordered. We found referring physician screenings in only 1 (10 percent) of 10 patient records reviewed. The facility identified this prior to our visit and was developing a new order entry procedure to ensure documentation of initial screening by referring physicians.

Safety Training. The American College of Radiology requires that MRI personnel and non-MRI personnel who

[16] VA Radiology, "Online Guide," <http://vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.

have access to the MRI area receive appropriate safety training. We reviewed the training records of six MRI personnel and six non-MRI personnel. All six MRI personnel had evidence of ongoing safety training. Two of the six non-MRI personnel did not have complete documentation of training.

Recommendations

16. We recommended that MRI personnel address any positive responses identified on the screening questionnaires and document actions taken and that referring physicians document initial MRI screenings.

17. We recommended that non-MRI personnel who have access to the MRI area receive the appropriate level of MRI safety training and that the training be documented.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and TJC's requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program.[17] We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 12 patients who transferred from the facility's acute inpatient unit, emergency department, or urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policy and TJC's standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions.[18] We reviewed the medical records of

[17] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[18] VHA Handbook 1907.01.

18 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether the facility had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[19] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. In general, influenza vaccinations were documented adequately for CLC residents. Also, we found that the pharmacy operated 24 hours a day, 7 days a week and had qualified staff to answer questions. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[20]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[21] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

[19] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[20] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[21] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements in 9 (90 percent) of the 10 records. The Suicide Prevention Coordinator recognized the need to consistently track safety plans and remind VA providers of the need for timely development of all safety plans. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 19–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[22]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	4	
CBOCs	Horsham, PA Philadelphia, PA Gloucester, NJ Fort Dix, NJ Camden, NJ	
Veteran Population in Catchment Area	336,253	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	142	
• **CLC/Nursing Home Care Unit**	135	
• **Other**	0	
Medical School Affiliation(s)	University of Pennsylvania	
• **Number of Residents**	108	
	Current FY (through May 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$409.6	$375.9
• **Medical Care Expenditures**	$409.6	$375.9
Total Medical Care Full-Time Employee Equivalents	1,972.5	1,918.9
Workload:		
• **Number of Station Level Unique Patients**	61,499	68,812
• **Inpatient Days of Care:**		
o **Acute Care**	27,698	44,177
o **CLC/Nursing Home Care Unit**	24,872	45,343
Hospital Discharges	3,774	5,433
Total Average Daily Census (including all bed types)	231.3	245.3
Cumulative Occupancy Rate	83.5%	88.5%
Outpatient Visits	338,625	471,688

[22] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Report data analyses to appropriate committees, and document, implement, and monitor corrective actions.	Action plans are not consistently documented.	N	Y (see page 3)
2. Document training of staff performing peer reviews, complete initial and final peer reviews in appropriate timeframes, and track and follow action items.	Data is timely documented and presented quarterly to the Medical Executive Committee.	Y	N
3. Require appropriate committees to track and trend patient complaint data.	Patient complaint data is tracked and results trended by the Patient Advocate and reported to the Quality Council on a semi-annual basis.	Y	N
4. Improve root cause analysis processing times.	Root cause analysis timeliness is a performance measure for Patient Safety staff, and monthly status reports are presented to the facility's Director.	Y	N
5. Ensure staff complete handoff communication education.	A handoff communications policy with an SBAR tool was developed, and staff were appropriately educated and trained in the use of the SBAR tool.	Y	N
6. Improve review of admission and continued stay cases not meeting facility criteria.	UM reports quarterly to the Quality Council. UM nurses have completed training in NUMI. The Fix Flow Committee, of which UM is an integral partner, meets weekly. Medicine UM reviewer attends daily medicine rounds.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
7. Require the Patient Flow Committee to meet regularly to implement and evaluate action plans.	Patient Flow Committee has been revamped to include key facility leaders. Minutes of meetings include documentation of assigned actions.	Y	N
EOC			
8. Require all EOC team members to participate in all rounds, rounds to be completed in CBOCs semi-annually, and documentation of all rounds to be complete.	EOC rounds are documented and conducted semi-annually in all CBOCs	Y, partially	Y (see page 9)
9. Ensure staff on 7E receive appropriate fire response and fire plan training and are issued fire extinguisher keys	Staff received keys and completed training.	Y	N
SHEP			
10. Develop and implement an action plan to improve patient care based on internal surveys and SHEP data results	A SHEP Subcommittee reports monthly to the Customer Service Committee.	Y	N
Computerized Patient Record System Business Rules			
11. Comply with VHA Handbook 1907.1 and the October 2004 OI guidance	The facility removed noncompliant business rules while inspectors were onsite at the time of the previous CAP.	Y	N
Surgical Care Improvement Project			
12. Develop Computerized Patient Record System templates for patients receiving post-anesthesia care.	Staff in post-anesthesia recovery received training and currently use only electronic documentation.	Y	N

VHA Satisfaction Surveys

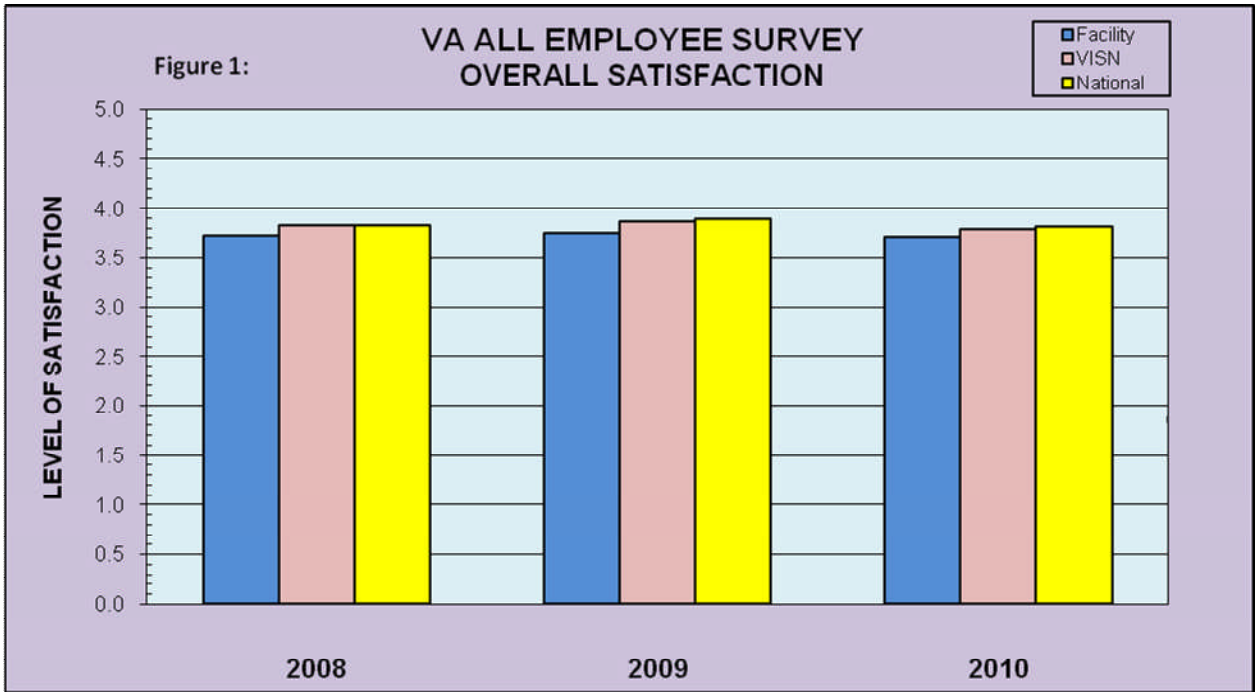
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	57.87	46.92	51.2	48.4	43.0	54.6
VISN	69.53	59.14	62.7	65.5	59.5	61.4
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[23] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	12.91	7.7	16.13	19.88	21.09	14.16
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[23] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: Dec. 7, 2010

From: Director, VA Stars and Stripes Healthcare Network (10N4)

Subject: **CAP Review of the Philadelphia VA Medical Center, Philadelphia, PA**

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

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the response to the draft OIG CAP report provided by the Philadelphia VA Medical Center and concur with the response. I am submitting it to your office as requested. If you have any questions or require additional information, please contact Barbara Forsha, VISN QMO at 412-822-3290.

(original signed by:)
MICHAEL E. MORELAND, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: Dec. 1, 2010

From: Director, Philadelphia VA Medical Center (642/00)

Subject: **CAP Review of the Philadelphia VA Medical Center, Philadelphia, PA**

To: Director, VA Stars and Stripes Healthcare Network (10N4)

We concur with the recommendations stated in the OIG CAP inspection report. Attached is our implementation plan showing specific corrective actions and target completion dates.

(original signed by:)
Joseph M. Dalpiaz
Medical Center Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that committee minutes identify action plans, assign responsibility, track open action items, and monitor implemented changes.

Concur

Target date for completion: January 31, 2011

The facility has a template for minutes that includes tracking of open items. The minutes need to be more robust in content so the reader knows exactly what is occurring. An education plan to train both the Chairpersons and the recorders of committee minutes will be developed. Target date for completion of education plan is December 30, 2010. The facility will schedule a mandatory training class regarding the preparation of minutes to include improving content, identifying action plans, assigning responsibility, tracking open action items and monitoring implemented changes. Required attendance is Committee Chairpersons and minute scribes. Target date for completion of training is January 31, 2011.

Recommendation 2. We recommended that PR extensions be requested in writing and approved by the facility's Director.

Concur

Target date for completion: October 31, 2010

The risk management team developed a tracking log to ensure that extensions are requested in a timely fashion. Facility is currently at 100 percent compliance. Facility will continue to monitor. This was completed on October 31, 2010.

Recommendation 3. We recommended that reporting of patient complaint data comply with VHA policy.

Concur:

Target date for completion: October 31, 2010

Patient complaint data has been changed to report quarterly to Quality Council. This data will be presented to executive leadership and other key staff who are members of Quality Council. Reporting calendar has been updated. Action completed October 31, 2010.

Recommendation 4. We recommended that the facility monitor the copy and paste functions in the electronic medical record.

Concur:

Target date for completion: September 21, 2010

A policy is in place and approved by Medical Records Committee. A tool has been developed for monitoring copying and pasting functions in the medical records and was implemented on September 21, 2010. Data will continue to be reviewed and monitored by the Medical Records Committee. Action completed on September 21, 2010.

Recommendation 5. We recommended that all physicians' profiles include sufficient OPPE data and that all privileges be setting specific.

Concur

Target date for completion: February 28, 2011

The facility has a process in place and is being used in the granting of provider privileges. Recent education was provided to key clinical leaders on the collection of OPPE data. The facility will implement a process to comply with VHA requirements for physician privileging and will make two attempts to get privileges from other institutions where the provider holds privileges.

Recommendation 6. We recommended that decontamination areas be restricted to authorized personnel.

Concur

Target date for completion: December 31, 2010

The facility will restrict access to decontamination areas to authorized personnel only.

Recommendation 7. We recommended that staff wear appropriate PPE in decontamination areas.

Concur

Target date for completion: January 31, 2011

The facility has a policy in place for PPE and staff has been educated on policy. Radiology and CT area completed re-education of staff on September 20, 2010. GU area to complete re-education on policy.

Recommendation 8. We recommended that ventilation system, air filter, and air exchange inspections be completed in accordance with VA policy.

Concur

Target date for completion: December 6, 2010

The facility has completed the required quarterly ventilation and air flow inspections and is in compliance with regulations. Initial inspection was completed on July 12, 2010. Subsequent inspection date was September 13, 2010. The next scheduled inspection is December 6, 2010. Action completed on December 6, 2010.

Recommendation 9. We recommended that SOPs for all pieces of RME be consistent with the manufacturers' guidelines and that staff follow the procedural steps in the SOPs.

Concur

Target date for completion: January 31, 2011

SOPs for RME have been developed and staff has been trained to follow the procedural steps in the SOPs.

Recommendation 10. We recommended that flash sterilization be used in the OR only in case of emergency and that ongoing monitoring of flash sterilization be continued.

Concur

Target date for completion: December 31, 2011

The facility will continue to monitor flash sterilization rate, analyze reasons for flash will be documented, and monthly reports provided to Infection Control Committee.

Recommendation 11. We recommended that the facility develop a plan of action to address the environmental hazard on the locked MH units that represents a threat to suicidal patients.

Concur

Target date for completion: Closed

The facility developed an immediate plan of action to address the environmental hazard on the locked MH units that represent a threat to suicidal patients. Monitoring is done daily and signed off by the EMS staff and Nursing Supervisor. The immediate plan of action put in place on September 17, 2010 is working well and has been implemented as a permanent process. Action completed on September 17, 2010.

Recommendation 12. We recommended that a self-assessment be conducted to ensure that issues with storage and labeling of medications, eyewash stations, and negative pressure rooms are identified throughout the facility and that corrective actions be taken as necessary.

Concur

Target date for completion: October 31, 2010

The facility will conduct a self assessment to ensure issues with storage and labeling of medications, eye wash stations, and negative pressure rooms are identified throughout the facility and that corrective actions are taken.

Recommendation 13. We recommended that dialysis staff consistently document biological testing.

Concur

Target date for completion: December 31, 2010

Biologic Testing of water and dialysate will be properly performed in dialysis area and results reported on a routine basis to Infection Control Committee.

Recommendation 14. We recommended that designated staff undergo annual OSHA Bloodborne Pathogen Rule training, locked MH unit environmental hazards training, and fit testing and training.

Concur

Target date for completion: April 30, 2011

The facility will conduct training for designated staff on OSHA Blood Borne Pathogen Rule, locked MH environmental hazards and fit testing.

Recommendation 15. We recommended that all EOC team members or their designees attend all EOC rounds and that attendance be documented.

Concur

Target date for completion: March 31, 2011

Staff performing CBOC rounds will be educated to sign for all areas that they review. Attendance will be documented and monitored.

Recommendation 16. We recommended that MRI personnel address any positive responses identified on the screening questionnaires and document actions taken and that referring physicians document initial MRI screenings.

Concur

Target date for completion: February 28, 2011

MRI personnel have been trained in MRI patient safety screening. Training completed on October 15, 2010. A template is under development for positive responses identified on screening questionnaires by referring physician to ensure documentation of initial MRI screenings. Template is to be completed by December 31, 2010. Target date for implementation of the template process is February 28, 2011.

Recommendation 17. We recommended that non-MRI personnel who have access to the MRI area receive the appropriate level of MRI safety training and that the training be documented.

Concur

Target date for completion: March 31, 2011

The facility will ensure that all MRI and non-MRI staff will receive appropriate level of MRI safety training and that the training is documented.

OIG Contact and Staff Acknowledgments

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