Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care and Environmental Conditions Northport VA Medical Center Northport, New York

Report No. 06-02548-21

November 6, 2006

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The inspection was conducted to investigate allegations concerning quality of care and inadequate environmental conditions at the Northport VA Medical Center, Northport, New York. An anonymous complainant sent a letter to the Secretary of Veterans Affairs alleging that:

- Registered nurses (RNs) lacked the appropriate credentials to order urinalyses and blood tests independently.
- Untrained health technicians (HTs) provided foot care to diabetic patients.
- Biomedical equipment in the emergency department (ED) lacked appropriate inspections and maintenance.
- Showers on two inpatient units malfunctioned and did not allow patients to take "proper" showers.
- Torn carpeting in the day treatment area created a fall risk.

We substantiated that RNs ordered urinalyses and blood tests and that these functions were not formally included in the RNs' scopes of practice. However, medical center managers identified the issue and began taking corrective actions prior to our site visit.

We did not substantiate that untrained HTs performed foot care for diabetic patients. We found that Podiatry Service trained and certified the competencies of HTs to provide limited foot care. Additionally, we found that biomedical employees inspected and maintained ED equipment, that showers on inpatient units functioned properly, and that carpeting in the day treatment area was in good repair.

We made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

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

SUBJECT: Healthcare Inspection – Quality of Care and Environmental Conditions, Northport VA Medical Center, Northport, New York

1. Purpose

The Department of Veteran Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), received allegations concerning quality of care and inadequate environmental conditions at the Northport VA Medical Center in Northport, New York. The purpose of this investigation was to determine the validity of the allegations.

2. Background

The medical center provides comprehensive health care through primary care, tertiary care, and long-term care. It also has community based outpatient clinics in Plainview, Patchogue, and Westhampton, New York; and four mental health satellite clinics in Islip, Lindenhurst, Lynbrook, and Riverhead, New York. The medical center is affiliated with the State University of New York Medical School at Stony Brook.

The Secretary of Veterans Affairs received a letter from an anonymous complainant on May 31, 2006. The complainant alleged that registered nurses (RNs) ordered urinalyses and blood tests without appropriate credentials and health technicians (HTs) provided foot care to diabetic patients without proper training. The complainant also alleged that medical equipment in the emergency department (ED) was not inspected and maintained and patients on two inpatient units were unable to take "proper" showers. Additionally, the complainant alleged that the carpeting in the day treatment area was torn and taped down, creating a fall risk.

The Office of the Secretary forwarded the letter to the Office of Healthcare Inspections for investigation.

3. Scope and Methodology

We visited the medical center on July 25–26, 2006, and interviewed the Associate Director for Patient and Nursing Services, nurse managers, and other appropriate nursing employees. We also interviewed the Chief of the Biomedical Section. We reviewed appropriate medical center policies and documents, reviewed competencies of the RNs on two inpatient units, and competencies of all HTs assigned to Primary Care. We also reviewed inspection and preventative maintenance records for equipment assigned to the ED, and we inspected a sample of equipment in the ED. Additionally, we inspected the two inpatient units where the showers were allegedly malfunctioning and the day treatment center where carpeting was allegedly torn and taped.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

4. Results

Issue 1: Registered Nurses' Competencies

We substantiated that RNs ordered urinalyses and blood tests without orders from licensed independent practitioners (LIPs) and that their scopes of practice did not reflect competencies for these functions. However, prior to our site visit, clinical managers identified this issue and began implementing corrective actions. They provided a draft copy of a medical center memorandum (MCM) addressing nursing clinical practice agreements in accordance with VHA policy.

The MCM allows RNs to request individual clinical practice agreements that privilege them to perform non-routine duties (such as independently ordering laboratory tests) according to their scopes of practice and advanced practice training. According to the MCM, the Chief of Staff, the Associate Director for Patient and Nursing Service, and the physicians in charge of the RNs assigned duty areas will authorize the clinical practice agreements. The MCM shows that RNs granted clinical practice agreements are required to complete 6 hours of education relevant to their requested clinical practice agreements. Their competencies will be reviewed annually. In conjunction with clinical practice agreements, the MCM also allows RNs to establish menu management agreements granting them access to specialized computer functions as defined in the clinical practice agreement.

At the time of our visit, managers had completed agreements with four RNs, three infection control nurses, and one RN assigned to ostomy[1] and wound management. The completed agreements listed the specific laboratory tests, diagnostic tests, and wound

[1] A surgically created artificial opening, usually through the abdominal wall, to allow for drainage of intestinal contents or urine.

dressings the four nurses could request. Clinical managers provided an acceptable timeline for full implementation of the agreements.

Issue 2: Health Technicians' Training

We did not substantiate that untrained HTs provided foot care to patients with diabetes. Eight HTs were assigned to Primary Care and were supervised by a nurse practitioner. We reviewed the training records for each HT. The records showed that Podiatry Service trained the HTs and certified their competencies to perform foot assessments and/or monofilament sensory foot examinations.[2] The training records of two of the HTs reflected an additional competency for trimming the toenails of non-diabetic patients.

The HT supervisor related that Primary Care did not provide foot care to diabetic patients beyond visual and sensory examinations and that Primary Care clinicians referred all patients with diabetes to Podiatry Service for foot care.

Issue 3: Outdated Biomedical Equipment Inspections

We did not substantiate that biomedical equipment inspections in the ED were outdated. We interviewed the Chief of the Biomedical Section who was responsible for medical equipment inspections and maintenance. Managers provided us with inspection and preventative maintenance records for all equipment assigned to the ED, and all the records were current. We toured the ED with the nurse manager and inspected 11 pieces of biomedical equipment. We found that inspection and maintenance stickers were current for all 11 items.

Issue 4: Environmental Conditions

We did not substantiate that patients on two inpatient units were unable to take proper showers. The complainant alleged that a medical-surgical unit and an acute psychiatric unit had malfunctioning showers. The complainant gave no specific information regarding the nature of malfunctions.

The medical-surgical unit had one congregate shower, and the nurse manager could not recall any complaints about the showers from either patients or employees. The showers on the acute psychiatric unit were located within patient rooms. The nurse manager recalled two patient complaints regarding water pressure. The nurse manager reported the complaints to Facility Management Service (FMS). FMS employees inspected the plumbing for all showers on the unit and adjusted the water pressure.

[2] The sensory testing device is a nylon filament mounted on a holder that has been standardized to deliver a 10 gram force when properly applied. Research has shown that a person who can feel the 10 gram monofilament in selected sites on the foot will not develop ulcers.

We inspected the shower in the congregate bath on the medical-surgical unit and several individual showers on the acute psychiatry ward. We found all areas to be clean with appropriate water temperature, water pressure, and drainage.

We did not substantiate that the carpeting in the day treatment area was torn, taped down, or posed a fall risk as the complainant alleged. We inspected the entire day treatment area and interviewed the nurse manager. The nurse manager did not recall torn carpeting in the area or any complaints of torn carpeting. A day treatment employee told us that in the past, the carpeting in an office was torn and taped down to prevent tripping, but the issue was resolved. We did not observe torn or taped carpeting in any patient care areas.

5. Conclusions

We concluded that RNs were ordering laboratory tests for patients independent of LIPs orders. However, clinical managers identified this issue and implemented acceptable policies and procedures to address it prior to our site visit. Additionally, managers provided an acceptable timeline for full implementation of the policies and procedures. We also concluded that training records for HTs supported that Podiatry Service trained HTs to perform visual inspections and sensory monofilament foot examinations. In addition, Podiatry Service trained two HTs to trim the toenails for non-diabetic patients.

We concluded that biomedical employees appropriately inspected and maintained ED equipment and all documentation to support this was current; also patient showers functioned properly. Additionally, the carpet in the day treatment area was intact and did not pose a fall risk.

6. Recommendations

We made no recommendations.

OIG Comments

The VISN and Medical Center Directors agreed with the report findings and conclusions. See Appendixes A and B (pages 5–6) for the Directors' comments.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 23, 2006

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

Subject: Healthcare Inspection – Quality of Care and Environmental Conditions, Northport VA Medical Center, Northport, New York

To: Assistant Inspector General for Healthcare Inspections

1. We concur with the conclusions from report Healthcare Inspection – Quality of Care and Environmental Conditions, Northport VA Medical Center, Project Number: 2006-02548-HI-03782.

2. Thank you for the opportunity to review the draft report, please contact Robert S. Schuster, VAMC Northport Medical Center Director at 631-754-7960 if you have additional questions.

(original signed by:)

JAMES J. FARSETTA, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 22, 2006

From: Director, Northport VA Medical Center

Subject: Healthcare Inspection – Quality of Care and Environmental Conditions, Northport VA Medical Center, Northport, New York

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

The Northport VAMC concurs with the findings of the draft report from the OIG Healthcare Inspection Team.

(original signed by:)
ROBERT S. SCHUSTER

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Jeanne Martin, Associate Director Bedford Office of Healthcare Inspections 781-687-3187
Acknowledgments	Rayda Nadal

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VISN 3(10N3)
Director, VA Medical Center (632/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Charles E. Schumer, Hillary Clinton
U.S. House of Representatives: Steve Israel

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.