Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02562-139

# Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, New York

June 3, 2009

Washington, DC 20420

## Why We Did This Review

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

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

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

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# Executive Summary

## Introduction

During the week of April 6–10, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Samuel S. Stratton VA Medical Center (the medical center), Albany, NY. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training for 199 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 2.

## Results of the Review

This CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Early Suicide Risk Detection.
- New Employee Orientation Initiative.
- Schwartz Center Rounds.

We made recommendations in six of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP review. For these activities, medical center managers needed to:

- Collect and analyze provider performance data and use the information to support reprivileging decisions.
- Appropriately identify and process institutional disclosures.
- Monitor the implementation and efficacy of corrective actions identified through the root cause analysis (RCA) process and report the status of action items to an appropriate committee.
- Develop a process to monitor the copying and pasting of text in the computerized patient record system (CPRS).
- Use patient complaint data to improve patient services and ensure that data are presented to the committee responsible for QM/performance improvement (PI) activities.
- Ensure that Emergency Department (ED) clinical staff obtain and maintain appropriate competencies.
- Improve security in the ED.

- Protect patient privacy and secure medical information in the ED.
- Improve the coordination of mental health (MH) services for community living center (CLC) patients.
- Ensure that all staff who clean patient isolation rooms have documented training.
- Enhance safety in the MH medication room.
- Ensure compliance with Veterans Health Administration (VHA) regulations governing medical record documentation for patients deemed at high risk for suicide.
- Ensure documentation of pain medication effectiveness within the required timeframe.

The medical center complied with selected standards in the following two activities:

- Contracted/Agency Registered Nurses (RNs).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Katherine Owens, Director, Bedford Office of Healthcare Inspections.

## Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–21 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

*(original signed by:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Introduction

## Profile

**Organization.** The medical center is a tertiary care facility located in Albany, NY, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 11 community based outpatient clinics (CBOCs) in Plattsburgh, Malone, Elizabethtown, Glens Falls, Clifton Park, Fonda, Schenectady, Troy, Bainbridge, Catskill, and Kingston, NY. The medical center is part of VISN 2 and serves a veteran population of more than 130,300 in upstate New York.

**Programs.** The medical center is a Clinical Referral Level 2 facility. It provides comprehensive health care through primary care, acute care (medicine, surgery, and psychiatry), tertiary care, and long-term care services. Additionally, the medical center provides physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics and extended care services.

**Affiliations and Research.** The medical center is affiliated with Albany Medical College and provides training for more than 100 residents annually. It also provides training for other health care professions, such as dentistry, nursing, pharmacy, social work, psychology, and physical therapy.

In fiscal year (FY) 2008, the medical center's research program had 65 projects and a budget of approximately $1 million. Important areas of research included obstructive bladder dysfunction and clinical trials involving oncology, hematology, and cardiology.

**Resources.** In FY 2008, the medical center's medical care expenditures totaled approximately $153 million. FY 2008 staffing was 1,146 full-time employee equivalents (FTE), including 84 physician and 334 nursing FTE.

**Workload.** In FY 2008, the medical center treated more than 31,700 unique patients and provided almost 24,000 acute inpatient days of care. In addition, the medical center provided over 15,000 inpatient days in its CLC.[1] The FY 2008 inpatient care workload (including CLC patients) totaled more than 2,600 discharges, and the average daily

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

census was 107. Outpatient workload totaled over 265,500 visits.

## Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care (E/UC) Operations.
- Environment of Care (EOC).
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and quarter 1 of FY 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review (*Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New*

*York,* Report No. 06-01136-193, August 18, 2006). In that report, we identified improvement opportunities in EOC and QM. During the follow-up review, we found sufficient evidence that managers had implemented appropriate actions to address the identified EOC deficiencies, and we consider those issues closed. For QM, we determined that the recommendation for provider performance monitoring had not been completely addressed; therefore, we reissued a recommendation.

During this review, we also presented fraud and integrity awareness briefings to 199 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

# Organizational Strengths

### Early Suicide Risk Detection

The medical center's Suicide Prevention Coordinator (SPC) developed a database that allowed the analysis of multiple clinical and demographic data sets. As a result, clinical managers were able to identify a cohort of patients in the rural northern areas of New York who were at risk for suicide because of concomitant diagnoses of depression and substance abuse. Once these patients were identified, the goal was to engage them in MH treatment early on, monitor their progress in treatment, and strengthen coordination of care before the patients exhibited overt suicidal symptoms, such as ideation or attempt at self-harm.

### New Employee Orientation Initiative

During FY 2008, the medical center moved away from the use of didactic learning techniques and initiated interactive, accelerated learning techniques to enhance new employee orientation. New employees teach themselves about key events in VA history by finding answers to questions through a series of informational posters placed at strategic points throughout the facility and discussing the information during orientation sessions. New employee satisfaction surveys consistently show that this interactive methodology is

effective, and the technique is scheduled to be expanded nationally.

### Schwartz Center Rounds

The Schwartz Center is a nonprofit organization founded by Kenneth B. Schwartz, a cancer patient who desired to strengthen the relationship between patients and their caregivers. Schwartz Center Rounds is a multidisciplinary forum where caregivers discuss difficult emotional and social issues that arise in caring for very ill patients. The medical center instituted Schwartz Center Rounds in 2008 and included such topics as "Breaking Bad News" and "Putting Compassion to the Test – When you Don't Want to Walk into the Room." Attendance has averaged 70 participants per session. Through satisfaction survey data, staff reported that the discussions improved patient care and working relationships with colleagues.

# Results

## Review Activities With Recommendations

### Quality Management Program

The purpose of this review was to evaluate whether: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported the program's improvement activities and appropriately responded to QM results; and (c) the medical center was in compliance with VHA regulations, local policies, and appropriate accreditation standards. To evaluate QM processes, we interviewed senior managers and the QM Coordinator, and we reviewed the self-assessment regarding compliance with QM requirements. Additionally, we evaluated policies, PI data, and other relevant documents.

The QM program was generally effective in its oversight of the quality of care provided at the medical center, and senior managers supported QM efforts through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified areas that needed improvement.

Provider Performance Monitoring. VHA regulations[2] require that clinical managers develop plans for continuous performance monitoring of the medical staff. According to the requirements, performance data should be ongoing,

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.

include indicators for continuing qualifications and competencies, and be reviewed and considered during the reprivileging process. We reviewed credentialing and privileging (C&P) folders and corresponding PI data for 22 providers reprivileged in the past 12 months and found that 10 (45 percent) had inadequate or no supporting QM/PI data for the privileges granted. This was a repeat finding from our previous CAP review.

Institutional Disclosure. VHA regulations[3] require that medical center managers disclose adverse events to patients. The regulations define two types of disclosures—clinical and institutional.[4] We reviewed the medical records of 18 patients who had clinical disclosures documented and determined that 4 (22 percent) of the cases met the criteria for an institutional disclosure.

RCA Process. We found that RCA reviews were generally thorough; however, it was difficult to track whether managers implemented corrective actions identified through the RCA process and whether corrective actions were monitored for efficacy, as required by VHA regulations.[5] At the time of the CAP review, the patient safety manager had primary responsibility for tracking implementation and monitoring corrective actions. However, the individual service managers who are responsible for implementation should be required to report the status of implementation and efficacy of the corrective actions to a senior-level committee.

Medical Record Documentation. At the time of our review, there were no processes to monitor the copying and pasting of medical information in CPRS, as required by VHA regulations[6] and local policy.

Patient Complaints. We found that the facility appropriately collected patient complaint data over time and identified improvement opportunities; however, we could not find evidence that managers implemented and monitored corrective actions, as required by VHA regulations.[7]

[3] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.
[4] Clinical disclosure is an informal process to discuss harmful events with patients and/or families. Discussions are documented in the medical record. Institutional disclosure is a formal process used in cases of serious injury, death, or potential legal liability. It includes information about compensation and the procedures available to request it.
[5] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[7] VHA Handbook 1003.2, *Service Recovery In The Veterans Health Administration*, February 4, 2004; VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005.

Additionally, we did not find that patient complaint data were presented to the committee responsible for QM/PI activities.

**Recommendation 1** We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize the information to support reprivileging decisions.

**Recommendation 2** We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers appropriately identify and process institutional disclosures.

**Recommendation 3** We recommended that the VISN Director ensure that the Medical Center Director requires that responsible managers monitor the implementation and efficacy of corrective actions identified through the RCA process and report the status of action items to an appropriate committee.

**Recommendation 4** We recommended that the VISN Director ensure that the Medical Center Director requires that responsible managers develop a process to monitor the copying and pasting of text in CPRS.

**Recommendation 5** We recommended that the VISN Director ensure that the Medical Center Director requires that managers use patient complaint data to improve patient services and ensure that data are presented to the committee responsible for QM/PI activities.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that service line managers are completing physician professional practice evaluation folders, which will contain provider-specific data for VA and contract providers. This will be completed by July 2009. They also reported that managers developed processes to ensure that institutional disclosures are appropriately identified and acted upon and to ensure that responsible managers report the status of RCA action items to the appropriate committees. Additionally, they reported that they are implementing improved processes to monitor the importing/copying of text into CPRS and to monitor and trend patient complaint data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Emergency/Urgent Care Operations

The purposes of this review were to evaluate selected aspects of E/UC operations, such as clinical services, consults, inter-facility transfers, staffing, and staff competencies. We also inspected the physical environment for cleanliness, safety, and equipment maintenance.

The medical center did not have a UC clinic but did have an ED that operated 7 days a week, 24 hours a day. We reviewed relevant VHA and medical center policies, and we interviewed the ED medical director and nurse manager. We also interviewed employees involved in managing transfers. Our review identified no issues with consults, transfers, staffing, and EOC. However, we identified the following areas that needed improvement.

Staff Competencies. We reviewed the C&P files of three ED physicians and found that the physicians were privileged for airway management; however, there was no evidence to support that the physicians completed the necessary training and competence validation. VHA regulations[8] require clinical managers to ensure the competence of clinicians who perform airway management outside of the operating room. At the time of our review, there was a plan in place to accomplish this, but it had not been implemented.

Additionally, we reviewed the competency folders of three ED RNs. The medical center's policy governing competencies requires that managers identify and verify the competencies necessary to perform safe patient care and that the competencies be role specific (for example, procedures or tasks performed in high-risk, problem-prone patient care areas). We found that service line managers responsible for the ED had not delineated specific mandatory competencies for ED nurses.

Safety. We found five unsecured entrances to the ED that could potentially allow unauthorized access into the area. Police presence was not visible, and the main police office was not located in an area that provided optimal protection for ED staff and patients.

Patient Privacy. VHA regulations[9] require that medical centers protect patient privacy and secure medical information. Due to the physical design and space

[8] VHA Directive 2005-031, *Out-of-Operating Room Airway Management,* August 8, 2005.
[9] VHA Handbook 1907.01.

limitations of the ED, there was a lack of auditory and visual patient privacy. Also, there were personnel located in the ED who were not essential to patient care. This could potentially further compromise patient privacy. Additionally, during our EOC rounds, we noted that there were two unattended computer monitors displaying patient information.

**Recommendation 6** We recommended that the VISN Director ensure that the Medical Center Director requires that ED clinical staff obtain and maintain competencies appropriate to their ED duties.

**Recommendation 7** We recommended that the VISN Director ensure that the Medical Center Director requires that security in the ED be improved.

**Recommendation 8** We recommended that the VISN Director ensure that the Medical Center Director takes action to protect patient privacy and secure medical information in the ED.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that ED physicians will complete airway management competencies and that ED specific competencies for RNs will be identified. They also reported that there are plans to improve safety, patient privacy, and medical information security. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Coordination of Care

The purpose of this review was to evaluate whether the medical center's inpatient consultations, intra-facility transfers, and discharges were coordinated appropriately over the continuum of care and whether the medical center was in compliance with VHA regulations, local policies, and accreditation standards. Coordinated consultations, transfers, and discharges are essential to integrated care processes that result in optimal patient care outcomes.

We found that providers managed intra-facility transfers and patient discharges appropriately. Additionally, consult responses were timely; however, we identified one patient consult process that needed improvement.

CLC MH Consults. We reviewed five inpatient MH consults for CLC patients. The consultants' recommendations included transferring patients' MH care to an outpatient MH

provider or to the MH provider in home-based primary care. However, we did not find documentation to support that continuity of MH care for these patients was provided.

**Recommendation 9** We recommended that the VISN Director ensure that the Medical Center Director requires that MH clinicians coordinate MH services for CLC patients.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the medical center hired a psychologist who will be assigned full-time to the CLC. This will improve MH treatment and continuity and coordination of care in the CLC. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA facilities are required to establish comprehensive EOC programs that fully meet VHA, Occupational Safety and Health Administration, and accreditation requirements.

We inspected the following areas: (a) two medical/surgical units, (b) the intensive care unit, (c) the acute MH unit, (d) two CLC units, (e) the dialysis unit, (f) the substance abuse residential rehabilitation treatment unit, (g) the dental clinic, (h) the Nutrition and Food Service kitchen, (i) the geriatric primary care clinic, and (j) one CBOC. The areas we inspected were clean and well maintained, and nurse managers expressed satisfaction with the housekeeping staff assigned to their areas. Additionally, we determined that managers identified environmental hazards on the acute MH unit that potentially posed threats to patients. The medical center provided documentation of risk assessment and abatement tracking of safety issues previously identified on the unit, and we found that unit staff had completed suicide risk training.

We also evaluated the IC program's management of data and processes in which the data were used to improve performance and found the program satisfactory. However, we identified two areas that needed improvement.

Training. *Clostridium difficile* (*C. difficile*)[10] is probably the

[10] *C. difficile* is a pathogen that causes gastrointestinal infections in humans.

most frequently identified cause of health care associated diarrhea and has been responsible for many large outbreaks in health care settings. The effects of *C. difficile* can range from diarrhea and abdominal discomfort to severe illness and death. Prevention focuses on accurate identification and isolation of affected patients, consistent hand hygiene practices, and environmental measures. Thorough cleaning of rooms that have housed patients with *C. difficile* diarrhea is an important intervention necessary to prevent transmission of the infection.[11]

We reviewed the training records of 60 employees identified by management as qualified to clean patient isolation rooms. We found that 11 (18 percent) of the records lacked evidence of training specific to the containment of *C. difficile*.

Staff Safety. The medication room on the acute MH unit has a window that opens out into the hall of the unit. Patients routinely come to the window to receive their medications. The location of the medication cart and other equipment in the room requires the nurse to turn his/her back to the window while he/she prepares medications. Since the nurse is not able to observe patients who may become agitated or aggressive while waiting for medications, this presents a potential safety risk.

**Recommendation 10** We recommended that the VISN Director ensure that the Medical Center Director requires that all staff designated as qualified to clean patient isolation rooms have documented training in the containment of *C. difficile.*

**Recommendation 11** We recommended that the VISN Director ensure that the Medical Center Director enhances the safety of the MH medication room.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that *C. difficile* training has been completed and documented and that a duress alarm was installed in the MH medication room to improve safety. The corrective actions are acceptable, and we consider Recommendations 10 and 11 closed.

## Suicide Prevention

The purpose of this review was to determine whether VHA health care facilities had implemented suicide prevention

[11] Under Secretary for Health Information Letter, IL 10-2005-018, *Clostridium Difficile* (*C. difficile*), September 8, 2005.

**Program**

programs that were in compliance with VHA regulations.[12] We assessed whether senior managers had appointed SPCs at facilities and very large CBOCs,[13] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[14] safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the SPC and reviewed pertinent policies. We found that the suicide prevention program was generally effective. The medical center had appointed an SPC who fulfilled all the required functions. The SPC had developed a tool to help staff effectively handle telephone calls from callers with suicidal ideation. However, we identified one area that needed improvement.

Medical Record Documentation. We reviewed the medical records for 10 patients placed on the high-risk list. We found PRFs for all 10 patients. However, we found that two (20 percent) of the records did not show evidence of safety plans and that seven (70 percent) did not show clear evidence of collaboration between the SPC and MH providers. Although we were told that the SPC consults with MH providers regularly, this was not clearly documented in the records.

**Recommendation 12**

We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans and SPC and MH provider collaboration for patients deemed at high risk for suicide.

The VISN and Medical Center Directors agreed with the findings and recommendations. They reported that the current list of high-risk patients will be reviewed to ensure that all patients have documented safety plans. Safety plan documentation for new patients added to the list will be monitored monthly. Additionally, managers will monitor documentation that supports the collaboration between the SPC and MH providers. The implementation plans are

[12] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[13] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled. The medical center did not have a very large CBOC.
[14] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

acceptable, and we will follow up on the planned actions until they are completed.

## Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management processes to ensure safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes on inpatient and CLC units, and we interviewed nurse managers and other nursing staff. Additionally, we observed nurses administering medications, and we asked patients whether nurses scanned their wristbands prior to administering their medications.

We found adequate management of medications brought into the medical center by patients or their families and determined that nurses scanned patients' wristbands prior to medication administration. However, we identified one area that needed improvement.

Pain Medication Reassessment. The medical center's policy governing pain management requires that pain reassessments occur within 60 minutes after the administration of PRN[15] pain medication. We reviewed 92 administered doses of PRN pain medications for the period of January 18–24, 2009, and found that pain reassessments for 42 (46 percent) of the doses were not documented within the designated timeframe.

**Recommendation 13** We recommended that the VISN Director ensure that the Medical Center Director requires the documentation of PRN pain medication effectiveness within the required timeframe.

The VISN and Medical Center Directors agreed with the finding and recommendation. They reported that the medical center changed the requirement for PRN effectiveness documentation to be consistent with community standards (4 hours). Nurse managers will monitor compliance monthly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

# Review Activities Without Recommendations

## Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as

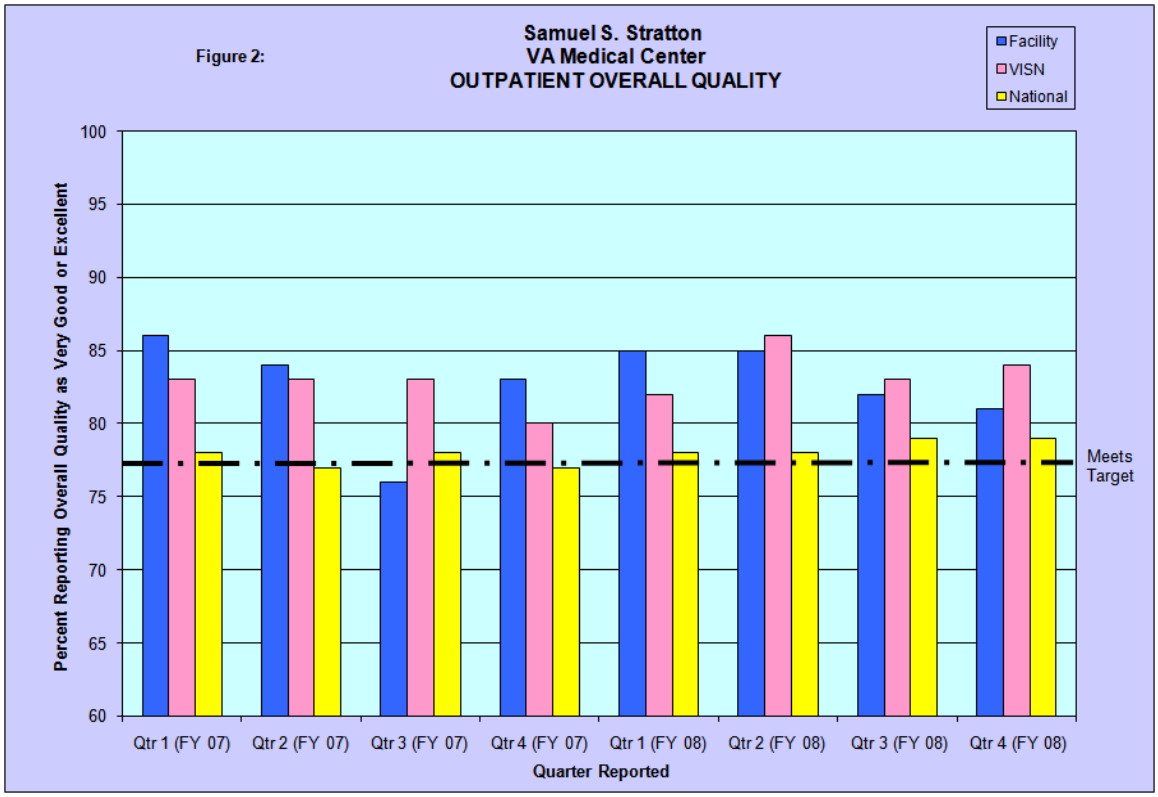
[15] PRN is a Latin abbreviation [L *pro re nata*] meaning as needed or as the circumstances require.

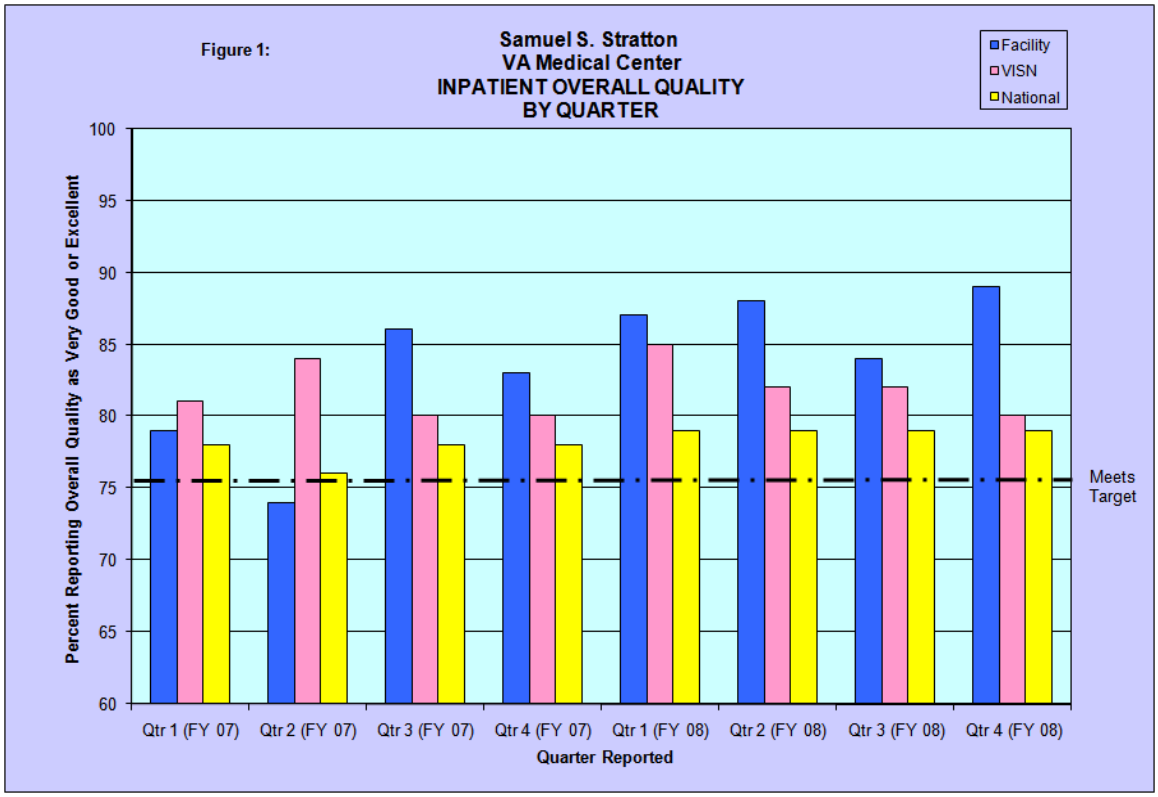
employees of VHA facilities. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed folders for 11 contracted/agency RNs who worked at the medical center. For all 11 RNs, documentation showed that managers had verified current licensure, life support certification, and competencies and that background checks had been completed. We also found documentation that 10 (91 percent) of the 11 RNs had completed the required information security and privacy training. We made no recommendations.

## Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA health care facilities used quarterly or semi-annual SHEP results to improve patient care and services. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. We reviewed SHEP scores for FYs 2007 and 2008. Figures 1 and 2 on the next page show the medical center's patient satisfaction performance measure results for outpatients and inpatients, respectively.

Figure 2:






Both outpatient and inpatient scores were above the target for 7 of 8 of the quarters reviewed. Managers analyzed SHEP data, identified service standards for further improvement, developed improvement strategies, and monitored the results of the strategies. Survey results and improvement strategies were distributed throughout the organization. We made no recommendations.

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** May 7, 2009

**From:** Network Director, VA Healthcare Network Upstate New York (10N2)

**Subject:** **Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York**

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

Director, Management Review Service (10B5)

I have reviewed the findings contained in the subject Combined Assessment Program Review conducted during the week of April 6, 2009. I concur with the facility action plans to resolve the identified findings.

STEPHEN L. LEMONS, Ed.D., FACHE

**Appendix B**

# Medical Center Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** May 7, 2009

**From:** Director, Samuel S. Stratton VA Medical Center (528A8/00)

**Subject:** **Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York**

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

Director, Management Review Service (10B5)

Our review of the findings contained in the subject Combined Assessment Program Review conducted during the week of April 6, 2009, has been completed. We concur with the findings noted therein, and submit for your review and approval our recommendations to resolve the identified findings.

MARY-ELLEN PICHÉ, FACHE
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 the VISN Director ensure that the Medical Center Director requires that clinical managers collect and analyze provider performance data and utilize the information to support reprivileging decisions.

Concur

Facility Response – By May 29, 2009 the Service Leads will have complete Physician Professional Practice Evaluation (PPPE) folders which include one full year of provider-specific quality data for all VA staff physicians. PPPE folders for contracted physicians will be complete by July 2009; all contract providers to be re-privileged prior to July will have complete PPPE folders to support reprivileging activities.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires that medical center managers appropriately identify and process institutional disclosures.

Concur

Facility Response – All view alerts for disclosures will be reviewed by the Chief of Staff for appropriate follow through, with Risk Management tracking of all disclosures.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director requires that responsible managers monitor the implementation and efficacy of corrective actions identified through the RCA process and report the status of action items to an appropriate committee.

Concur

Facility Response – A stand down for open and overdue actions is scheduled for May 11, 2009. The backlog will be resolved on this date. Management champions are held accountable for the follow-through and completion of RCA actions. Follow-through is monitored through the Patient Safety Committee, which reports quarterly on the status of actions to the Health Systems Committee.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires that responsible managers develop a process to monitor the copying and pasting of text in CPRS.

Concur

Facility Response – Subsequent to comprehensive retraining, all reviews conducted after May 8, 2009 will include an audit of the importing/copying of text in the electronic medical record. Results of these audits will be monitored through the Health Information Management System Committee, who will provide quarterly reports to the Executive Committee of the Medical Staff.

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director requires that managers use patient complaint data to improve patient services and ensure that data are presented to the committee responsible for QM/PI activities.

Concur

Facility Response – The Marketing and Communications Committee (MCC) is responsible for the identification and follow-through of actions based on analysis of patient satisfaction and complaint data. The Patient Advocate will include a separate analysis of patient complaint data and actions to the quarterly report to the Local Leadership Council through the Marketing and Communications Committee (MCC). Patient complaint action items will be included in quarterly reports of operations at the Network level.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that ED clinical staff obtain and maintain competencies appropriate to their ED duties.

Concur

Facility Response – A statement will be added to the facility competency policy in May 2009, requiring all work areas to have annual competency plans. ED specific competencies for nurses will be identified in May 2009, and the physician testing portion of competency for airway management will be completed by May 15, 2009.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director requires that security in the ED be improved.

Concur

Facility Response – The five ED access points were reviewed and prioritized for action based on location, use, accessibility, and risk level rating. The ambulance and main hallway entrances will be locked 24/7 with swipe card access by September 2009; the critical path item for this change is lead time for the vendor to obtain parts. Procurement of the needed parts will be expedited. Regarding the remaining three access points, the doorway to the MEV building is already controlled as this is a 24/7 secured area with access controlled at the check-in desk. Stairwells 11 and 12 have very limited traffic and are primarily used by staff.

Police support and observation is strong based on the following:

- ED is equipped with duress alarms monitored by VA Police.
- ED staff maintains a portable radio to contact VA Police as needed.
- ED has two security cameras which are monitored by VA Police; one observes the AOD check in area (main hallway) and one the ambulance bay entrance.
- VA Police maintain both administrative and operational areas within the left branch of the ED allowing for almost immediate response as needed.
- VA Police make routine checks of the ED as part of daily patrol operations.

**Recommendation 8.** We recommended that the VISN Director ensure that the Medical Center Director takes action to protect patient privacy and secure medical information in the ED.

Concur

Facility Response – Pending completion of a planned construction project, reallocation of space within the existing ED will be completed in May 2009 to address patient privacy and medical information security concerns. Modifications to, and realignment of, existing ED space will allow for additional treatment areas as well as a partitioned area for the physicians to work and meet with families.

**Recommendation 9.** We recommended that the VISN Director ensure that the Medical Center Director requires that MH clinicians coordinate MH services for CLC patients.

Concur

Facility Response – A Gero-Psychologist for the CLC has been hired and is scheduled to start May 2009. This will improve CLC mental health treatment, continuity, and coordination of care. This clinician is one hundred percent assigned to the CLC, with twenty hours per week dedicated to being on the unit.

**Recommendation 10**. We recommended that the VISN Director ensure that the Medical Center Director requires that all staff designated as qualified to clean patient isolation rooms have documented training in the containment of *C. difficile.*

Concur.

Facility Response – A new process was instituted in April 2009 for the documentation of FMS trainings. All trainings (formal and informal) are recorded in TEMPO and the descriptions of each training will be more specific to identify all the elements of the training. *C. difficile* training was completed in April 2009 for all staff who clean patient isolation rooms.

**Recommendation 11.** We recommended that the VISN Director ensure that the Medical Center Director enhances the safety of the MH medication room.

Concur.

Facility Response – A duress button was installed in the medication room on the inpatient Mental Health unit on May 5, 2009.

**Recommendation 12.** We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans and SPC and MH provider collaboration for patients deemed at high risk for suicide.

Concur.

Facility Response – All patients on the High Risk List will have a Safety Plan upon discharge from inpatient acute psychiatry or at the next outpatient appointment. All current patients on the High Risk List will be reviewed and verified for a documented safety plan in CPRS by May 18, 2009. All Flag Management will document collaboration between the SPC and the Mental Health Provider. A monthly monitor was initiated on May 1, 2009, on all new patients to ensure completion of a safety plan.

A monitor will be put in place in May 2009, verifying documentation of collaboration between the SPC and the Mental Health Providers on Flag Management, ensuring full implementation of the process.

**Recommendation 13.** We recommended that the VISN Director ensure that the Medical Center Director requires the documentation of PRN pain medication effectiveness within the required timeframe.

Concur.

Facility Response – Pain assessment and reassessment are based on the type of medication used and the patient's response to pain. The facility pain policy has been changed to increase the timeframe for documentation of the pain reassessment to 4 hours. Both Joint Commission and OIG reviewers identified the 4-hour documentation time frame as community standard. Education of RN and LPN staff will be complete by May 29, 2009. Nurse Managers will monitor adherence to this policy on a monthly basis. Daily reporting of timely documentation is currently available to Nurse Managers each day and Monday morning for the weekends.

# OIG Contact and Staff Acknowledgments

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