Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00474-14

Combined Assessment Program Review of the Northport VA Medical Center Northport, New York

October 27, 2010

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

ACLS	Advanced Cardiac Life Support
BLS	Basic Life Support
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CPRS	Computerized Patient Record System
EOC	environment of care
ESA	erythropoiesis stimulating agent
facility	Northport VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
HgbA1c	Hemoglobin A1c
IC	infection control
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
MSEC	Medical Staff Executive Committee
NFS	Nutrition and Food Service
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PPE	personal protective equipment
PSB	Professional Standards Board
QM	quality management
RME	reusable medical equipment
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Northport VA Medical Center, Northport, NY

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 August 2, 2010.

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

- Magnetic Resonance Imaging Safety
- Medication Management
- Suicide Prevention Safety Plans

The facility's reported accomplishments were the diabetes wellness program and the Nutrition and Food Service collaborative cultural transformation.

Recommendations: We made recommendations in the following five activities:

Quality Management: Peer review findings should be reported to the Medical Staff Executive Committee quarterly, and extensions should be approved in writing by the facility's Director. Designated staff need to maintain current life support certification, and the local resuscitation policy should be reviewed annually and updated.

Physician Credentialing and Privileging: Clinical managers should fully develop professional practice evaluations.

Reusable Medical Equipment: Facility managers need to ensure that standard operating procedures are current and consistent with manufacturers' instructions and are device-specific. Staff entering the decontamination area should put on appropriate personal protective equipment. All Veterans Health Administration required reusable medical equipment elements should be reported to the Medical Staff Executive Committee.

Environment of Care: Designated employees should receive annual respirator fit testing. The facility should provide the required bloodborne pathogens training.

Coordination of Care: Clinicians should use VA's "Inter-Facility Transfer Form" or an electronic equivalent and include all required information. Patients' dietary requirements should be correctly and consistently recorded in discharge documentation.

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
Healthcare Inspections

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care 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

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
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through April 30, 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 Northport VA Medical Center, Northport,*

New York, Report No. 07-00577-171, July 19, 2007). The facility had corrected all findings.

During this review, we also presented crime awareness briefings to 64 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

Diabetes Wellness Program

The facility diabetic PI team created a diabetes wellness program with the goal of providing one-stop diabetes care to veterans. The program supports a multidisciplinary clinic that provides diabetes related services, such as primary care, retinal eye exams, foot exams, and medication and nutrition education, in one place. Patients wishing to attend the program clinic are prescreened for various health factors and previous diabetes education. The team held its first diabetes wellness program clinic in April 2009.

Patient appointments are at 1.5-hour intervals, and each patient receives a "passport" type document with designated clinic areas indicated. Forty-nine patients attended the first three clinics held in April, July, and August 2009. Ninety-eight percent of attendees said they felt the diabetes wellness program was helpful. In addition, those with HgbA1c levels greater than 9, an indicator of poor blood glucose control, decreased from 69 percent to 31 percent following clinic attendance. In addition, average HgbA1c levels decreased from 9.89 percent prior to clinic attendance to 8.18 percent following attendance. Quarterly program clinics have experienced steadily increasing enrollment with 50 patients attending the May 2010 clinic.

NFS Collaborative Cultural Transformation

Because resident satisfaction surveys indicated significant dissatisfaction with all aspects of food in the CLC, NFS and nursing embarked on a plan to improve meal service to CLC residents. A Resident Menu Group involved residents in the process, and participating divisions included Voluntary Service, medicine, Environmental Management Service, logistics, pharmacy, and social work.

Five days a week in the CLC, there are now food-based specials, including dessert day, special meals, grilled to order breakfast, snack baskets, and fresh baked cookies. Room service for lunch is available daily on the palliative care unit. These sustainable meal service improvements resulted from the flexibility of the facility's staff as well as processes that continually change based on resident input.

Through the promotion of resident-centered care, the facility experienced an increase in resident satisfaction survey scores from 69 percent prior to cultural transformation to a sustained 83 percent and higher. The most significant factor was the improvement in food choices and quality. In addition, residents experienced a marked reduction in unplanned weight loss, an increase in socialization, and an improvement in the culture of the resident community.

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. We evaluated policies, PI data, and other relevant documents, and we interviewed appropriate senior managers, patient safety employees, and the QM Coordinator.

The facility's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified two areas that needed improvement.

Peer Review. VHA policy requires peer review findings to be reported to the MSEC on a quarterly basis.[1] Final reviews of peer review cases are to be completed within 120 days from the date it was determined that a peer review was needed, and any extensions must be approved in writing by the facility's Director. The peer review process was comprehensive and generally in compliance with VHA requirements. However, MSEC minutes for 3 of the 4 quarters reflected that peer review findings were not discussed. Additionally, we found 12 peer reviews that were

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

completed beyond the 120-day limit, and no written extensions had been approved by the facility's Director.

Life Support Training. VHA policy requires implementation of a system that monitors ACLS and BLS training and ensures timely renewal of all certifications.[2] In addition, VHA policy requires managers to delineate actions to be taken for noncompliance. Managers identified 156 employees who are required to have ACLS certification; however, 5 (3 percent) did not have current certifications. Managers identified 964 employees who are required to have CPR/BLS certification; however, 101 (10 percent) did not have current certifications. Additionally, the local policy was outdated, was not reviewed annually, and did not identify actions to be taken when certifications were not current.

Recommendations

1. We recommended that facility managers ensure that peer review findings are reported to the MSEC quarterly and that peer review extensions are in writing and approved by the facility's Director.

2. We recommended that designated staff maintain current ACLS and BLS certification in accordance with local policy and that facility managers review the resuscitation policy annually and update it to include actions to be taken when ACLS and BLS certification is not current.

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.[3] We also reviewed the minutes of PSB meetings during which discussions about the physicians took place.

We reviewed C&P files and profiles for 10 physicians. The physicians were either appointed to the medical staff or reprivileged within the past 12 months. We found that licenses were current and that primary source verification had been obtained.[4] However, we identified the following area that needed improvement.

[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[4] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner.

Professional Practice Evaluations. VHA policy requires specific competency criteria for FPPE and OPPE for all privileged physicians. PSB meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. However, we did not find sufficient performance data in the physicians' profiles, as required by VHA policy. Although clinical managers had developed service-specific criteria for practice evaluations, FPPE and OPPE were not in place for all physicians at the time of our review. We did not find FPPEs for three physicians—one physician was recently hired, and two physicians had requested additional privileges. In addition, in four of the seven applicable profiles, we did not find sufficient measurable OPPE data to support reprivileging for the 4 previous quarterly periods.

Recommendation

3. We recommended that clinical managers fully develop FPPEs and OPPEs for all physicians prior to granting requested privileges or reprivileging.

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, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD area and the gastrointestinal clinic reprocessing areas and did not identify any EOC issues. However, we identified the following areas that needed improvement.

SOPs. VHA requires facilities to establish device-specific SOPs for reprocessing RME based on current manufacturers' instructions.[5] We found that the SOPs for the bronchoscope, cystoscope, transesophageal ultrasound probe, colonoscope, prostate biopsy probe, and laparoscope were not consistent or current—based on manufacturers' instructions—and/or were not device-specific. In addition, the SOP and competency for the prostate biopsy probe were

[5] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

inconsistent. While attempting to identify which document was correct, the facility discovered that they did not have a current copy of the manufacturer's instructions, and they could not locate a copy of the instructions due to the age of the equipment. Managers stated that they would immediately locate a copy of the manufacturer's instructions and make corrections to the SOP and competency as appropriate.

PPE. VHA requires personnel to put on PPE before entering the decontamination area. We observed SPD and non-SPD staff entering the area without the appropriate gloves, face shields, and approved hair coverings.

Reporting. VHA requires specific RME elements to be reported to the MSEC. We found that the MSEC did not receive reports on validation of initial and ongoing staff competencies, SOP compliance, and risk management activities.

Recommendations

4. We recommended that facility managers ensure that SOPs are current and consistent with manufacturers' instructions and are device-specific.

5. We recommended that SPD and non-SPD staff entering the decontamination area put on appropriate PPE.

6. We recommended that all VHA required RME elements be reported to the MSEC.

EOC

The purpose of this review was to determine whether the facility complied with selected IC standards and maintained a clean and safe health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We conducted onsite inspections of the locked acute MH unit, the medical telemetry unit, the surgical rehabilitation unit, the intensive care unit, the palliative care unit, and two CLC units. We also inspected the emergency department, the radiology department, the women's health clinic, and a primary care clinic. The facility maintained a generally clean and safe environment. Nurse managers and staff expressed satisfaction with the responsiveness of the housekeeping staff on their units.

VHA requires that locked inpatient MH units be free of ligature points and that furnishings be physically heavy or secured to the floor to prevent them from being overturned, thrown, or used as weapons.[6] The locked acute MH unit had wardrobes with doors and hinges that could be potential ligature points. Also, several chairs were neither heavy nor secured to the floor. Managers replaced the chairs with heavy chairs and provided us with an action plan to modify the wardrobe hinges. Therefore, we made no recommendations for these findings.

Hospital equipment and surfaces in patient care areas must be maintained in good condition and cleaned to reduce the spread of infections. We found torn covers on several pieces of equipment and silk medical tape used to repair broken and loose objects. Staff removed the torn items from service and submitted work orders for the items that required repairs; therefore, we made no recommendations for these findings. However, we identified the following areas that needed improvement.

N95 Respirator Fit Testing. CDC guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza (swine flu) should wear, at a minimum, a fit tested N95 respirator.[7] In addition, OSHA standards require designated staff to be medically cleared, fit tested, and trained for respirator use as part of a complete respiratory protection program. We reviewed selected fit testing records and found that none of the five radiology employees and that only one of five bronchoscopy suite employees had received annual N95 fit testing.

Bloodborne Pathogens Training. OSHA requires that employees with occupational exposure risk receive annual training for bloodborne pathogens. We reviewed training records of selected employees and found that IC training was provided; however, the content did not meet OSHA's bloodborne pathogens training requirements.

Recommendations

7. We recommended that designated employees receive annual respirator fit testing.

[6] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," August 3, 2010.
[7] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

8. We recommended that the facility provide bloodborne pathogens training, as required.

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 JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires facilities to have a policy that ensures the safe, appropriate, and timely transfer of patients. We found that the facility had recently appointed a Patient Transfer Coordinator and had implemented a process to monitor and evaluate inter-facility transfers, as required by VHA policy. The facility also had a policy addressing discharge planning, and our review of discharge documentation for 15 patients found that clinical staff initiated discharge planning early using an interdisciplinary approach. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation.[8] VHA also requires facilities to use VA Form 10-2649A, "Inter-Facility Transfer Form" (hardcopy or electronic equivalent).

We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient units or emergency department to another facility during the 6-month period December 2009 through May 2010. For 8 of the 10 patients, providers did not use VA Form 10-2649A or an equivalent. Instead, specific details about the transfers were documented in various places in the medical records. The documentation did not address all of the required information, such as level of care needed, medical requirements during transportation, and informed consent. As a result, it was not always clear what information was communicated with receiving facilities, in what form the information was communicated, or who communicated the information.

[8] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Discharges. VHA policy requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions.[9]

We reviewed the medical records of 15 patients discharged in May and June 2010 and found that for 4 patients (27 percent), discharge documentation, such as instructions and summaries, orders, and nursing and patient education notes, contained inconsistent dietary information. As a result, it was not clear if these patients received consistent dietary information and education prior to discharge.

Recommendations

9. We recommended that the facility require providers to use VA Form 10-2649A, "Inter-Facility Transfer Form," or an electronic equivalent to document all inter-facility transfers and ensure that all required information is documented.

10. We recommended that facility managers implement procedures to correctly and consistently record patients' dietary requirements in discharge documentation.

Review Activities Without 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 ESAs.[10] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. We also found that clinical staff adequately documented influenza vaccinations for CLC residents. We made no recommendations.

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.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key

[9] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.
[10] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment as required by The JC.

The facility had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Staff directly observed patients in the magnet room at all times. Two-way communication was available between patients and the MRI technologists, and patients had access to a push-button call system while in the scanner.

Local policy requires that personnel who have access to the MRI areas receive appropriate MRI safety training. We reviewed the training records of 10 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received MRIs. In all cases, patients received appropriate screenings. In addition, four patients who received contrast media had signed informed consents prior to the procedures as required by local policy. 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.[11]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[12] 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. We reviewed the

[11] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[12] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

medical records of 10 patients assessed to be at high risk for suicide.

In 1 of the 10 records, we did not find a safety plan. While we were onsite, a provider called the patient and scheduled an appointment to develop a safety plan. Therefore, 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 16–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[13]		
Type of Organization	Tertiary care medical center	
Complexity Level	Clinical Referral Level 1	
VISN	3	
CBOCs	Patchogue, NY Plainview, NY Riverhead, NY Islip, NY Lindenhurst, NY Lynbrook, NY	
Veteran Population in Catchment Area	Over 160,000	
Type and Number of Total Operating Beds: • **Acute Care**	306	
• **CLC/Nursing Home Care Unit**	170	
• **Other**	30 Substance Abuse Residential Rehabilitation Treatment Program	
Medical School Affiliation(s)	Stony Brook University Medical Center	
• **Number of Residents**	200 (2009/2010)	
	Current FY (through May 2010)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$258.8	$241.3
• **Medical Care Expenditures**		$241.3
Total Medical Care FTE	1,750.2	1,685.8
Workload:		
• **Number of Station Level Unique Patients**	29,607	33,172
• **Inpatient Days of Care:**		
o **Acute Care**	27,889	36,065
o **CLC**	27,675	33,216
Hospital Discharges	2,114	2,578
Total Average Daily Census (including all bed types)	76.1	127.5
Cumulative Occupancy Rate	50.3%	70.18%
Outpatient Visits	234,338	342,555

[13] 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. Require the Patient Care Review Committee to report at least quarterly to the medical executive staff and managers to improve PI reporting processes to assure that PI action items are consistently identified, implemented, and monitored for efficacy by an appropriate monitoring committee.	Documentation confirms that the committee is reporting quarterly to the Clinical Executive Board.	Y	N
EOC			
2. Modify or remove looped eye hasps from patient lockers on the inpatient psychiatric units to improve patient safety.	Lockers in question have been replaced.	Y	N
CPRS Business Rules			
3. Require managers to review CPRS business rules at least annually to guarantee compliance with VHA regulations.	Documentation confirms that CPRS business rules are reviewed semi-annually and that results are reported to the Clinical Informatics Committee.	Y	N

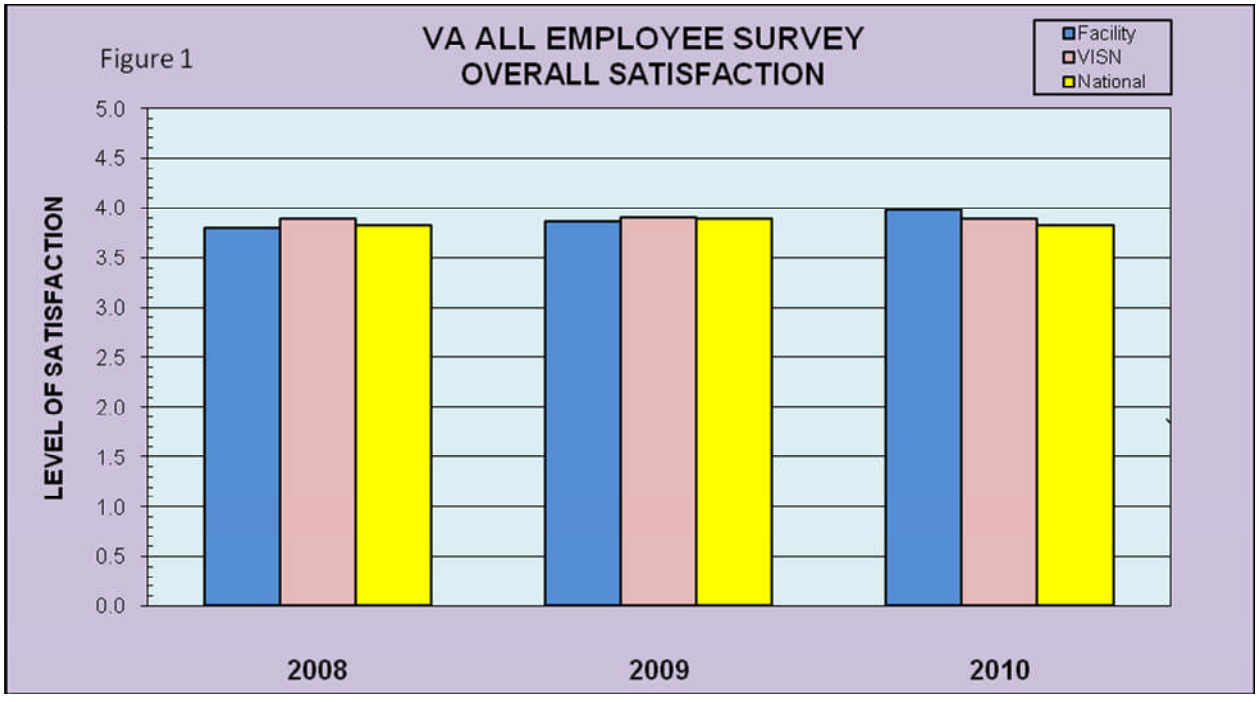
VHA Satisfaction Surveys

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	66.77	60.42	67.2	69.2	59.4	56.1
VISN	67.28	56.36	61.4	63.3	58.4	56.6
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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[14] 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 patient 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	14.54	8.64	15.02	20.05	22.27	17.49
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[14] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, the 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 heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 18, 2010

From: VISN 3 Network Director (10N3)

Subj: **CAP Review of the Northport VA Medical Center, Northport, NY**

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

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

Attached please find the Combined Assessment Program (CAP) draft response from Northport VAMC.

I have reviewed the draft report from the Northport VAMC and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at Northport VAMC.

MICHAEL A. SABO, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 18, 2010

From: Director of Northport VAMC (632/00)

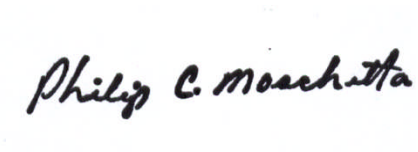
Subj: **CAP Review of the Northport VA Medical Center, Northport, NY**

To: Director, VA NY/NJ Veterans Healthcare Network (10N3)

I want to express my appreciation to the Office of the Inspector General (OIG) survey team for their professional and comprehensive combined assessment program (CAP) review conducted on August 2–6, 2010.

I have reviewed the report for the Northport VAMC and I concur with the findings and recommendations.

I appreciate the opportunity for this review as an important part of the continuing process to improve the care to our veterans.



PHILIP C. MOSCHITTA

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 facility managers ensure that peer review findings are reported to the MSEC quarterly and that peer review extensions are in writing and approved by the facility's Director.

Concur **Implementation Date: 9/14/2010**

Quarterly Peer Review Reporting schedule set up with office of Chief of Staff to include timeliness, action documentation and trend analyses. Medical Staff education was completed regarding director approval for Peer Review extensions beyond 120 days.

Recommendation 2. We recommended that designated staff maintain current ACLS and BLS certification in accordance with local policy and that facility managers review the resuscitation policy annually and update it to include actions to be taken when ACLS and BLS certification is not current.

Concur **Implementation Date: 10/18/2010**

The facility defines who requires life support training. The facility systematically tracks training status through the Learning Management System. The facility is currently amending the Center Memorandum 00-127 to include "appropriate action when needed training is not maintained." The CM shall be completed and implemented within 90 days. All Staff compliant with CPR certification by 10/18/10. Performance of an annual review will be conducted by the CPR/Code Committee regarding training of staff and performance of CPR at the facility, ensuring that policies are updated as needed or as new guidance is received and for ensuring that all changes and new policies are communicated effectively to all staff members of the facility.

Recommendation 3. We recommended that clinical managers fully develop FPPEs and OPPEs for all physicians prior to granting requested privileges or reprivileging.

Concur **Implementation Date: 12/1/2010**

FPPE will be implemented for all new providers and providers requesting new privileges. The FPPE will be documented in the C&P/PSB minutes. Service chiefs will provide patient profile data incorporating the six general competencies for OPPE.

Recommendation 4. We recommended that facility managers ensure that SOPs are current and consistent with manufacturers' instructions and are device-specific.

Concur **Implementation Date: 11/5/2010**

1. All staff involved in use & reprocessing of RME have completed training and are competized annually. Device specific SOPs and competencies for reprocessing according to manufacturer's instructions have been implemented. SOPs for the bronchoscope, cystocope, transesophageal ultrasound probe, colonoscope, prostate biopsy probe and laparoscope have been reviewed and updated according to manufacturer's instructions and are now device specific.

Implementation Date: 10/1/2010

2. Due to the age of Siemens Sonoline ultrasound probe, current manufacturer's instructions were not available. The manufacturer was contacted and supplied operating instructions for Siemens model Sonoline Prima ultrasound probe. SOP and competencies have been updated to follow manufacturer's operating instructions for Universal Needle Guide cleaning and sterilization. The operating room is exploring the purchase of a new prostate ultrasound machine.

Recommendation 5. We recommended that SPD and non-SPD staff entering the decontamination area put on appropriate PPE.

Concur **Implementation Date: 10/6/2010**

An in service was provided the week of August 7th to all SPD staff. An SOP was written that requires appropriate PPE for SPD staff on entry into the decontamination room. Process implemented to have the operating room staff don gloves prior to transporting any case carts to decontamination. Process was presented to operating room staff meeting 10/6/10.

Recommendation 6. We recommended that all VHA required RME elements be reported to the MSEC.

Concur **Implementation Date: 11/9/2010**

VHA Directive 2009-004 was reviewed and monthly reports regarding Risk Management, Quality Management and validation of SOPs and competencies, both initial and annual to be presented to the Clinical Executive Board (CEB) monthly. This process will begin with the November CEB.

Recommendation 7. We recommended that designated employees receive annual respirator fit testing.

Concur **Implementation Date: 10/19/2010**

Radiology and Bronchoscopy suite employees identified as staff requiring fit testing and training for N95 respirators. Respiratory Questionnaires sent to affected staff. Fit testing in progress. Staff unable to be fitted due to facial hair etc. will be required to use PAPR (Powered Air Purifying Respirator).

Recommendation 8. We recommended that the facility provide bloodborne pathogen training, as required.

Concur **Implementation Date: 2/28/2011**

A more comprehensive training has been developed and will be added to mandatory education for all employees (clinical, EMS and pharmacy) with potential exposure to blood borne pathogens. This mandatory training will be implemented by 12/1/10. Measure of success – 100% of employees (clinical, EMS and pharmacy) with potential for exposure to blood borne pathogens will be trained.

Recommendation 9. We recommended that the facility require providers to use VA Form 10-2649A, "Inter-Facility Transfer Form," or an electronic equivalent to document all inter-facility transfers and ensure that all required information is documented.

Concur **Implementation Date: 8/1/2010**

The Point of Contact (POC) is actively tracking all interfacility transfers to/from Northport and ensures the interfacility transfer form is being completed along with consents. The POC is active in VISN group and is utilizing VISN worksheet.

Recommendation 10. We recommended that facility managers implement procedures to correctly and consistently record patients' dietary requirements in discharge documentation.

Concur **Implementation Date: 11/1/2010**

Clinical dietitians assigned to medical units have been added to "huddle" mail group, to obtain list of patients scheduled for discharge the next day. Also, will attend daily huddle rounds, when clinically appropriate. During that huddle, nutritionist will verify diet orders with clinicians. The clinicians will be in-serviced by 11/1/10. Measure of success: ten charts monthly will be reviewed for consistent dietary discharge information. Review until 100 percent for 3 months.

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