Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03664-88

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

February 16, 2012

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

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
ED	emergency department
EOC	environment of care
facility	Samuel S. Stratton VA Medical Center
FY	fiscal year
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, 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 November 14, 2011.

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

- Colorectal Cancer Screening
- Coordination of Care
- Medication Management
- Psychosocial Rehabilitation and Recovery Centers
- Quality Management

The facility's reported accomplishments were implementation of a lipid management clinic and a modified readmission risk assessment tool.

Recommendations: We made recommendations in the following three activities:

Moderate Sedation: Ensure that pre-sedation assessment documentation is completed within the required timeframe.

Polytrauma: Ensure that interdisciplinary teams develop polytrauma treatment plans and that a trained rehabilitation nurse is made available to the polytrauma program.

Environment of Care: Ensure that patient care areas are clean, that daily function tests are performed on the community living center's elopement prevention system and documented, and that infection control risk assessments are conducted prior to the initiation of construction projects.

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.

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:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FYs 2010 and 2011 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 of the facility

(*Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York,* Report No. 08-02562-139, June 3, 2009). The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 88 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 132 responded. Survey results were shared with facility managers.

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

Reported Accomplishments

Lipid Management Clinic

Facility clinical pharmacists worked with the Primary Care Lead Physician to identify patients who were not meeting their low-density lipoprotein goal despite receiving lipid-lowering therapy. Clinical pharmacists generated a patient list for each primary care and community based outpatient clinic team and contacted the patients by telephone to complete an education session and to invite them to participate in the Lipid Management Clinic. The pharmacists adjusted medications, scheduled laboratory tests, and communicated with patients to assist them in bringing low-density lipoprotein levels to within the desired range. When patients reached an acceptable low-density lipoprotein goal, they graduated from the clinic back to the primary care provider for continuation of long-term monitoring. This approach has been successful for 74 percent of these patients.

Modified Readmission Risk Assessment Tool

In June 2011, the Inpatient-Patient Centered Improvement Team rolled out an initiative to reduce readmissions. Upon admission, each patient is given a score using a modified risk assessment tool. This tool predicts a patient's risk for readmission by considering factors such as age, length of stay, previous admissions within 6 months, number of medications, and co-morbid conditions. Since its implementation, the facility has reduced all-cause readmissions from 17.3 percent to 14.7 percent and has reduced the average days from discharge to follow-up appointment from 10.2 days to 7.4 days. During the FY 2011 VHA Patient Care Coordination Collaborative, the team was chosen to present this initiative and the facility's success to date.

Results

Review Activities With Recommendations

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, six medical records, and training/competency records, and we interviewed key individuals. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[1] Two patients' medical records did not have a history and physical examination and/or a pre-sedation assessment documented by the provider within the required timeframe.

Recommendation

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation is completed within the required timeframe.

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2006.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, nine medical records with positive TBI results, and training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that a specific interdisciplinary treatment plan be developed for each polytrauma outpatient who needs interdisciplinary care.[2] The interdisciplinary team's plan must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. Four of the medical records we reviewed did not have the required treatment plans.

Staffing. VHA requires that minimum staffing levels be maintained and that specific disciplines be included.[3] The facility did not have a trained rehabilitation nurse available for the polytrauma care program.

[2] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[3] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Recommendations

2. We recommended that processes be strengthened to ensure that interdisciplinary teams develop polytrauma treatment plans.

3. We recommended that a trained rehabilitation nurse be made available to the polytrauma program.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Substance Abuse Residential Rehabilitation Treatment Program was in compliance with selected Mental Health Residential Rehabilitation Treatment Program requirements.

We inspected a behavioral health unit, one medical and one surgical inpatient unit, an intensive care unit, and a CLC unit. We also inspected the dental and physical therapy clinics, the emergency department, the operating room suite, and the Substance Abuse Residential Rehabilitation Treatment Program. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	Mental Health Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The Joint Commission requires that areas used by patients be clean. In 4 of the 11 areas inspected, we found heavy layers of dust on countertops, shelving, and furniture. In addition, we found that metal hardware in most bathrooms was grossly stained or rusted.

Patient Safety. VHA requires that daily checks be performed on elopement prevention systems in CLCs.[4] We did not find documentation of 24-hour function checks for the elopement prevention system in the CLC.

Infection Prevention. Local policy requires that an infection control risk assessment be conducted prior to the initiation of any construction project. We found that a risk assessment was not conducted prior to the renovation of a medication room in the medical inpatient unit and that construction dust covered work areas and medication packaging.

Recommendations

4. We recommended that processes be strengthened to ensure that patient care areas are clean.

5. We recommended that processes be strengthened to ensure that daily function tests are performed on the CLC's elopement prevention system and documented.

6. We recommended that infection control risk assessments be conducted prior to the initiation of construction projects.

[4] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 3, 2010.

Review Activities Without Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of heart failure received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of heart failure management key components.

We reviewed 25 heart failure patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of Mental Health Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of Mental Health Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

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 21–25 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[5]		
Type of Organization	Tertiary care medical center	
Complexity Level	1c	
VISN	2	
Community Based Outpatient Clinics	Bainbridge, NY Catskill, NY Clifton Park, NY Elizabethtown, NY Fonda, NY Glens Falls, NY Kingston, NY Malone, NY Plattsburgh, NY Saranac Lake, NY Schenectady, NY Troy, NY	
Veteran Population in Catchment Area	56,709	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	98	
• **CLC/Nursing Home Care Unit**	50	
• **Other**	N/A	
Medical School Affiliation(s)	Albany Medical College	
• **Number of Residents**	Total number of full-time employee equivalent allocations = 62.9 Total number of trainees in medical college program = 367	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$199.2	$193.9
• **Medical Care Expenditures**	$203.4	$193.8
Total Medical Care Full-Time Employee Equivalents	1,222	1,205.9
Workload:		
• **Number of Station Level Unique Patients**	40,227	83,319
• **Inpatient Days of Care:**		
o **Acute Care**	7,668	16,814
o **CLC/Nursing Home Care Unit**	7,231	14,453
Hospital Discharges	1,466	2,941
Total Average Daily Census (including all bed types)	82	85.6
Cumulative Occupancy Rate (in percent)	65	68
Outpatient Visits	139,725	284,955

[5] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure clinical managers collect and analyze provider performance data and use the information to support reprivileging decisions.	Service leads completed professional practice evaluation folders, which include provider-specific quality data. The Professional Standards Board analyzes the practice information to make recommendations for medical staff appointments, reappointments, and granting of privileges.	N
2. Ensure facility managers appropriately identify and process institutional disclosures.	The Chief of Staff now reviews all "view alerts" for disclosures generated by the template disclosure note. Patient incident reports, Administrator on Duty reports, reports of contact, peer review, and morbidity/mortality are also evaluated for disclosure.	N
3. Ensure managers monitor the implementation and efficacy of corrective actions identified in root cause analyses and report the status of action items to an appropriate committee.	Follow-through is monitored through the Patient Safety Committee, which reports quarterly on the status of actions to the Health Systems Committee.	N
4. Ensure managers develop a process to monitor the importing/copying of text into the Computerized Patient Record System.	The use of importing/copying of text has been added to record reviews and is reported to the Health Information Management System Committee.	N
5. Ensure that managers use patient complaint data to improve patient services and that data is presented to the committee responsible for QM/performance improvement activities.	The Customer Service Steering Committee is responsible for the identification and follow-through of actions based on analysis of patient satisfaction and complaint data.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Emergency/Urgent Care Operations		
6. Ensure ED clinical staff obtain and maintain competencies appropriate to their ED duties.	A policy was developed after the CAP review and has been implemented and maintained.	N
7. Ensure that security in the ED is improved.	Installation of swipe card access was completed on November 6, 2009.	N
8. Ensure action is taken to protect patient privacy and secure medical information in the ED.	Reallocation of existing ED space to allow for privacy was completed June 30, 2009. A comprehensive project to address all ED EOC needs is pending with a targeted completion date of 2012.	N
Coordination of Care		
9. Ensure that mental health clinicians coordinate mental health services to CLC patients.	The CLC psychologist instituted daily contact with CLC programs to provide continuity of care for CLC residents. He initiated weekly Psychology Rounds for the CLC staff to address individual staff concerns and patient care issues pertaining to mental health.	N
EOC		
10. Ensure that all staff designated qualified to clean patient isolation rooms have documented training in the containment of *Clostridium difficile*.	A new process was instituted in April 2009 to document training for the Facility Management Service. All training (formal and informal) is recorded, and the training description will be more specific to identify all elements. *Clostridium difficile* training was completed in April 2009 for all staff who clean patient isolation rooms.	N
11. Ensure that the safety of the mental health medication room has been enhanced.	A duress button was installed in the medication room on the inpatient mental health unit on May 5, 2009.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Suicide Prevention		
12. Ensure compliance with VHA policy regarding documentation of safety plans and Suicide Prevention Coordinator and mental health provider collaboration for patients deemed at high risk for suicide.	The Suicide Prevention Coordinator updated the high-risk patient tracking database on June 1, 2009, to include fields for flag completions and has developed a routine report and system to ensure all veterans added to the high-risk list have a safety plan. Those patients on the high-risk list without a safety plan were identified, and a safety plan was accomplished with each veteran by August 31, 2009.	N
Medication Management		
13. Ensure documentation of PRN (as needed) pain medication effectiveness within the required timeframe.	Education of registered nurses and licensed practical nurses was completed on May 29, 2009. Daily reports are generated by the Bar Code Medication Administration Coordinator, capturing every PRN (as needed) pain medication administered and the documentation of effectiveness. This report is reviewed and discussed each day by the Associate Director of Patient/Nursing Service and nurse managers.	N

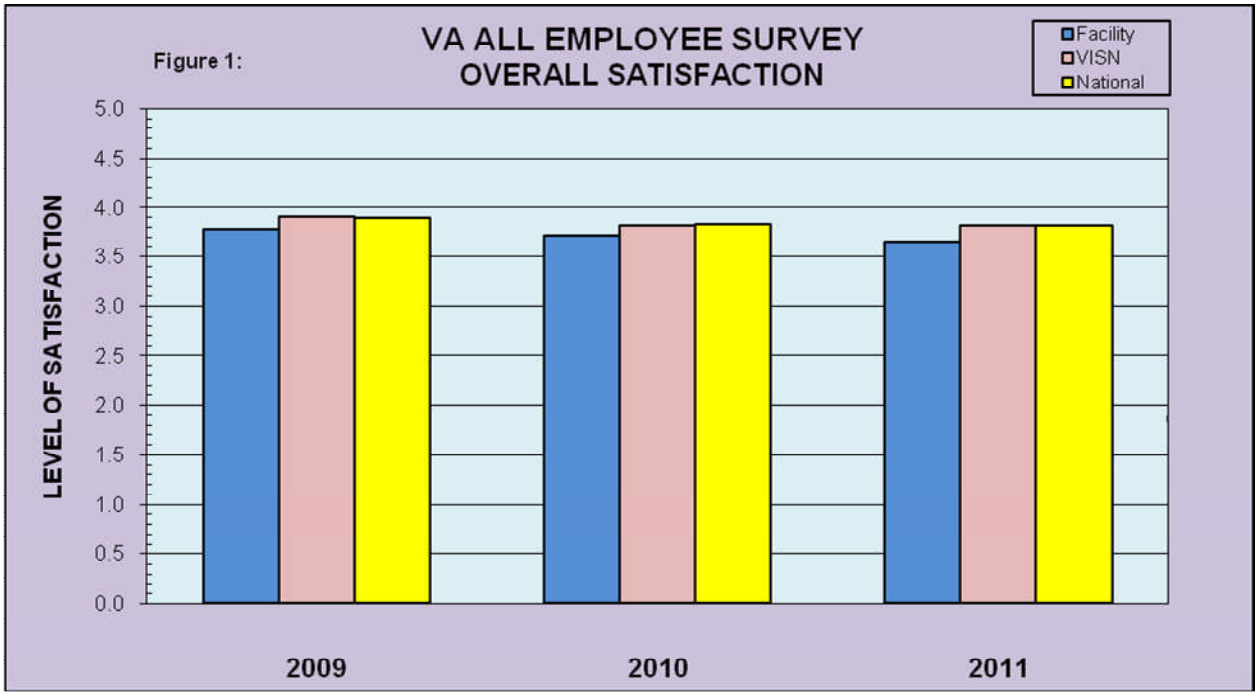
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	67.6	58.7	68.1	59.3	63.0	58.6
VISN	68.9	58.9	66.4	60.9	61.8	58.4
VHA	64.1	54.4	63.9	55.9	55.3	54.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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.[6] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[7]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	17.2	12.7	14.4	20.7	28.0	18.3
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 13, 2012

From: Director, VA Health Care Upstate New York (10N2)

Subject: **CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

I concur with the recommendations listed in the Office of Inspector General's report, CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY.

Signed by Darlene A. DeLancey for
David J. West, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 11, 2012

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

Subject: **CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

To: Director, VA Health Care Upstate New York (10N2)

I concur with the recommendations listed in the Office of Inspector General's report, CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY.

/Signed/
LINDA W. WEISS, MS, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation is completed within the required timeframe.

Concur

Target date for completion: Template completed November 21, 2011.

Facility's response:

The template for 2C-Ambulatory Surgical Unit (ASU) "Time out observation and intraoperative observation" template has been revised to include documentation that the doctor has done a pre-sedation exam. There has been compliance, since this form has been revised. The ASU Nurse Manager will continue to monitor for three months to ensure compliance. Monitor through March 2012 using chart reviews.

Recommendation 2. We recommended that processes be strengthened to ensure that interdisciplinary teams develop polytrauma treatment plans.

Concur

Target date for completion: Completed January 11, 2012. Monitor quarterly through chart reviews.

Facility Response:

Effective immediately, the polytrauma clinic team will make sure that every patient fitting the criteria in the VHA Directive for needing a comprehensive interdisciplinary treatment plan will have one in place.

Recommendation 3. We recommended that a trained rehabilitation nurse be made available to the polytrauma program.

Concur

Target date for completion: Completed January 31, 2012. Monitor quarterly through chart reviews.

Facility Response:

Our facility has identified a nurse for the polytrauma clinic team that will be utilized as part of the interdisciplinary treatment team and planning process.

Recommendation 4. We recommended that processes be strengthened to ensure that patient care areas are clean.

Concur

Target date for completion: Ongoing hiring progress through 2012.

Facility Response:

Staff investment will result in an increase in housekeeping aides and supervisory oversight of sanitation operations. Increased surveillance from Facilities Management Staff to ensure cleanliness issues are identified and addressed on an ongoing basis, until hiring process is complete. The Hospital Housekeeping Officer will report monthly to the Environment of Care Committee related to staffing and cleanliness. Weekly monitoring & monthly reporting through the Environment of Care Committee related to facility cleanliness.

Recommendation 5. We recommended that processes be strengthened to ensure that daily function tests are performed on the CLC's elopement prevention system and documented.

Concur

Target date for completion: February 17, 2012 for approval of Standard Operating Procedure (SOP). Monitoring for Roam Alert System will be done for three months through May 2012.

Facility's Response:

SOP GEC-20: Geriatric and Extended Care Community Living Center (CLC): Management of Wandering Residents using the Roam Alert System is under revision and the draft copy is out for concurrence. The process for a daily checklist for the Roam Alert System and a monthly checklist for patients was added to the current SOP. The checklists were implemented immediately and being used by both Community Living Centers (CLC's).

Recommendation 6. We recommended that infection control risk assessments be conducted prior to the initiation of construction projects.

Concur

Target date for completion: Completed December 14, 2011. Monitoring by Facilities Management Staff and the Infection Prevention Nurse will be done for three months through April 2012.

Facility's Response:

Infection Prevention Nurse was routinely meeting with our facility Project Section every other Thursday and is now meeting routinely with Faculties Management Staff for in-house projects every other Wednesday. Infection Control Risk Assessments (ICRA's) are in place for all projects that meet the requirements as per facility policy and Center for Engineering & Occupational Safety and Health (CEOSH) guidelines.

OIG Contact and Staff Acknowledgments

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