Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-00471-201

Combined Assessment Program Review of the VA New York Harbor Healthcare System New York, New York

July 21, 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 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 26–30, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the VA New York Harbor Healthcare System (the system) New York, 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 to 444 system employees. The system is part of Veterans Integrated Service Network (VISN) 3.

Results of the Review

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

- Virtual Reality (VR) Psychotherapy Treatment
- Beacon Award for Critical Care Excellence

We made recommendations in five of the activities reviewed. For these activities, the system needed to:

- Trend and analyze outcomes data related to the use of reversal agents in conjunction with moderate sedation.
- Fully develop and implement physician professional practice evaluations and ensure that Professional Standards Board (PSB) meeting minutes reflect discussions regarding performance data.
- Ensure that new employees complete initial training and that managers validate competencies annually for all pieces of reusable medical equipment (RME).
- Establish comprehensive device-specific standard operating procedures (SOPs) that are consistent with manufacturers' recommendations and Veterans Health Administration (VHA) requirements and ensure that employees follow the SOPs.
- Ensure that employees put on appropriate personal protective equipment (PPE) when entering and remove PPE when leaving decontamination areas.
- Fully implement the system's flash sterilization action plan and restrict flash sterilization use to emergent situations.

- Ensure that clinicians document that patients at high risk for suicide and/or their family members receive copies of suicide prevention safety plans.
- Require staff to complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.
- Ensure that discharge summaries and instructions include all required elements and that information is consistent.

The system complied with selected standards in the following three activities:

- Environment of Care (EOC)
- Magnetic Resonance Imaging (MRI) Safety
- Medication Management

This report was prepared under the direction of Claire McDonald, Director, Boston Regional Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 18–25, for the full text of the Directors' comments.) We consider Recommendation 7 closed. We will follow up on the planned actions for the remaining recommendations until they are completed.

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

Introduction

Profile

Organization. The system has three campuses located in Manhattan (New York), Brooklyn, and Queens (St. Albans CLC). It offers a broad range of inpatient and outpatient health care services. The system also provides primary care at three community based outpatient clinics located in New York, Brooklyn, and Staten Island, NY. The system is part of VISN 3 and serves a veteran population of approximately 187,000 in the counties of New York, Kings, Queens, and Richmond.

Programs. The system provides a full range of patient care services, including primary care, tertiary care, and long-term care. It has 318 hospital beds, 179 community living center (CLC) beds, and 74 residential treatment beds.

The New York campus is a tertiary care facility that provides services in acute medicine, surgery, acute psychiatry, neurology, and rehabilitation medicine. The campus is a referral center for cardiac surgery and neurosurgery.

The Brooklyn campus provides services in acute medicine, surgery, psychiatry, and residential substance abuse. Specialized programs include comprehensive cancer care and non-invasive cardiology.

The St. Albans CLC provides primary care, specialized geriatric care, rehabilitation, geropsychiatric care, and general nursing home care.

Affiliations and Research. The system is affiliated with the New York University Langone Medical Center and with the State University of New York Downstate Medical Center. It provides training for 270 medical residents, as well as other disciplines, including dentistry, optometry, podiatry, psychology, nursing, pharmacy, social work, dietetics, respiratory therapy, and pastoral care.

In fiscal year (FY) 2009, the system's research program had 199 human and animal research projects and a budget of approximately $4 million. Important areas of research included cardiovascular, substance abuse, rehabilitation engineering/prosthetics, and geriatrics as well as clinical trials and cooperative studies.

Resources. In FY 2009, medical care expenditures totaled over $533 million. The FY 2010 medical care budget is more than $542 million. FY 2009 staffing was 3,578 full-time employee equivalents (FTE), including 244 physician and 624 nursing FTE.

Workload. In FY 2009, the system treated 51,500 unique patients and provided 78,941 inpatient days in the hospital, 52,465 inpatient days in the CLC, and 22,592 inpatient days in residential treatment programs. The hospital's inpatient workload totaled 10,181 discharges, and the average daily census was 195. The CLC had 230 discharges and an average daily census of 143, and the residential treatment programs had 833 discharges and an average daily census of 62. Outpatient workload totaled 710,802 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:

- Coordination of Care
- EOC
- Medication Management

- MRI Safety
- Physician Credentialing and Privileging (C&P)
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through the 2nd quarter 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 system (*Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York,* Report No. 07-00766-11, October 23, 2007).

During this review, we also presented fraud and integrity awareness briefings for 444 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

Virtual Reality Psychotherapy Treatment

The system has two post-traumatic stress disorder (PTSD) clinical teams at each of the main campuses that serve one of the largest cohorts of veterans with PTSD in VHA. The system offers a wide array of individual and group treatments, including demographic and combat era specific groups. Emphasis is on evidence-based treatments, including VR treatment provided to a select group of patients. VR is a computer-based system that presents a multi-media visual, auditory, and olfactory representation of trauma-related environments to the veteran. The goal of VR is to develop customized scripts and scenarios titrated to the veteran's level of tolerance in order to gradually extinguish pathological responses to trauma-related stimuli. The flexibility of VR in crafting these scenarios allows for highly individualized treatment.

Beacon Award for Critical Care Excellence

The Brooklyn campus intensive care unit (ICU) has twice received the Beacon Award for Critical Care Excellence. The American Association of Critical Care Nurses, the largest specialty nursing organization in the world, created the award in 2003 to challenge acute and critical care nurses to improve the care provided to critically ill patients. The rigorous application process and competitive award provides the critical care community with a quantitative and qualitative method to measure achievements in professional practice, patient outcomes, and the health of the work environment. The Brooklyn ICU is the only VA facility—and the only ICU in New York City—to have received this distinction.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers, patient safety employees, and the QM coordinator.

The system'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 the following area that needed improvement.

Moderate Sedation. VHA policy requires systems to monitor outcomes related to the use of moderate sedation, including reporting and trending the use of reversal agents.[1] Outcomes data must be systematically aggregated and analyzed to enhance patient safety and performance. We found no evidence that the system trended or analyzed outcomes data related to the use of reversal agents in conjunction with moderate sedation.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires managers to trend and analyze

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

outcomes data related to the use of reversal agents in moderate sedation.

The VISN and the System Directors agreed with the finding and recommendation. The current reporting process will be revised to include all the parameters for monitoring. Pharmacy Service will report all reversal administrations to QM for review. Review results will be trended and reported quarterly to the Operative and Other Invasive Procedures Review Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the system 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.[2] We also reviewed PSB meeting minutes during which discussions about the physicians took place.

We reviewed 20 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained.[3] However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA policy requires specific competency criteria for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) for all privileged physicians. FPPE is a process in which the facility evaluates the competence of the physician when his or her practice is unfamiliar to the facility, when his or her practice has raised concerns, or when he or she has learned a new skill. We did not find an FPPE for the one newly hired physician.

OPPEs allow the facility to identify professional practice trends that impact physicians' privileges. Although clinical managers had developed service-specific criteria for practice evaluations, they did not have sufficient provider-specific data for 18 (90 percent) of the 20 physicians for the previous 12-month OPPE period. Furthermore, meeting minutes did not reflect detailed discussions of physicians' performance

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification.

data prior to granting initial privileges or reprivileging, as required by VHA policy.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that clinical managers fully develop and implement practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting initial privileges or reprivileging.

The VISN and the System Directors agreed with the findings and recommendation. The Professional Standards and Credentialing Board (PS&CB) reviewed and approved plans for OPPE for established physicians/providers and for FPPE for newly privileged physicians/providers and/or for granting new privileges to established physicians/providers. FPPE will be reviewed within 6 months for new providers and semi-annually for all privileged physicians/providers. PS&CB minutes will reflect the review of FPPE and OPPE. All service chiefs were instructed to review and revise current practice evaluations to ensure sufficient provider-specific data. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system had processes in place to ensure effective reprocessing of RME. Improperly reprocessed RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The system's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected multiple areas at the New York and Brooklyn campuses and the St. Albans CLC (as listed below) where disinfection of RME took place:

- New York Campus
  - Cardiology
  - Dental
  - Genitourinary (GU)
  - Gastrointestinal (GI)
  - Radiology

  - Operating Room (OR)
  - SPD Decontamination and Clean Areas

- Brooklyn Campus
  - Cardiology
  - Dental
  - Ear-Nose-Throat
  - GU
  - GI
  - Radiology
  - Hemodialysis
  - OR
  - SPD Decontamination and Clean Areas

- St. Albans CLC
  - Dental
  - SPD Decontamination and Clean Areas

VA requires that decontamination areas comply with specific environmental standards for air pressure, emergency plans, sanitation, and safety.[4] We determined that the system had established appropriate guidelines for reprocessing RME and monitored compliance with those guidelines. However, we identified the following areas that needed improvement.

Competencies and Training. VHA requires that all employees involved in the use and reprocessing of RME have initial training and annual competency on the set-up, use, reprocessing, and maintenance of each piece of RME.[5] We observed the disinfection or sterilization of 12 pieces of RME and reviewed the competency folders of the employees who performed the RME reprocessing. Documentation of annual competencies was not available for two employees, and the competency for one SPD employee at the New York campus was not device-specific. Additionally, device-specific RME training was not documented for a new SPD employee at the New York campus.

SOPs. VHA policy requires that RME reprocessing SOPs reflect manufacturer recommendations and that SOPs are

[4] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements;* August 16, 2002.
[5] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

followed.[6] We observed the reprocessing of a total of 12 pieces of RME. In two areas, employees failed to follow the guidelines recommended by the manufacturer and/or the SOP. Also, a local SOP required the use of clean transport containers to return RME to the clinic for immediate use or to a storage location. We observed an employee placing a newly cleaned piece of RME in a transport container labeled as dirty. In another area, an employee failed to completely follow the SOP or operate the automatic endoscope reprocessor (AER) appropriately. Upon further questioning of the staff in the area where the AER was located, we found a general lack of knowledge about some of the AER's features. While we were onsite, the system held a staff training session with an AER company representative.

We determined that an SOP for cleaning dental instruments was not consistent with manufacturer recommendations, and the bronchoscope SOP did not include instructions for the automatic flushing equipment that staff used to clean the bronchoscope. We also found that many of the SOPs for sterilizing RME in the New York campus SPD were not device-specific, as required by VHA.

VA requires that biological monitoring tests are performed on all sterilizers every day.[7] If the test is positive, specific actions, including a written report to the Chief of Staff, the Surgical Service Chief, and the Infection Control Committee, must occur. The New York campus's OR SOP outlining actions to be taken following a positive biological testing result was not consistent with the process required by VHA.

PPE. VA requires that specific attire be put on before entering and removed upon leaving decontamination areas.[8] We observed staff entering the Brooklyn campus SPD and New York campus GI disinfection areas without appropriate attire and staff exiting three decontamination areas without removing all PPE.

Flash Sterilization. VA requires that flash sterilization (a shorter sterilization process) be used for unanticipated events only and not for the purpose of routine sterilization of surgical instruments.[9] Items commonly used in surgery that

[6] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements,* June 26, 2009.
[7] VA Handbook 7176.
[8] VA Handbook 7176.
[9] VA Handbook 7176.

are in ample supply in SPD are not considered appropriate for flash sterilization. The New York campus OR flash sterilization log included items such as scissors, skin hooks, and forceps that should be in adequate supply in SPD and easily replaceable during a surgical procedure. The system had recently identified a high flash sterilization rate and had developed an action plan to address the high rate.

Recommendation 3 We recommended that the VISN Director ensure that the System Director enforce the requirement that new employees receive initial training and that managers validate competencies annually for all pieces of RME.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires managers to establish comprehensive device-specific SOPs that are consistent with manufacturers' recommendations and VHA requirements and ensure that employees follow the SOPs.

Recommendation 5 We recommended that VISN Director ensure that the System Director requires employees to put on appropriate PPE when entering and remove PPE when leaving decontamination areas.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires managers to fully implement the system's flash sterilization action plan and restrict flash sterilization use to emergent situations.

The VISN and the System Directors agreed with the findings and recommendations. All personnel folders related to any personnel involved in RME were reviewed and assessed with respect to competencies, initial training, and ongoing training. Competencies for each employee will be reviewed quarterly. All new employees will receive specific training for the RME they are responsible for cleaning. Competencies and training records will be placed in each employee's RME folder with the SOP.

All equipment was reviewed to ensure that comprehensive device-specific SOPs and written manufacturers' instructions for use and processing were in place and current. No piece of equipment will be allowed into service until the RME Committee has approved the SOP and has assured competency training for all associated personnel.

All personnel involved in any aspect of RME were required to demonstrate the appropriate use of PPE. All associated policies and procedures were reviewed, and it was emphasized that the policies, procedures, and SOPs must be fully implemented at all times. Additionally, PPE in-services were scheduled for all RME areas.

A flash sterilization plan was implemented on March 1, 2010. The plan was reviewed with OR nurse managers, SPD supervisors, the Chiefs of Surgery, and OR nursing staff. A walk-through of the process was done with all of the above, and it was emphasized that the policy must be followed without exception. Nurse managers will be required to approve all instances of flash sterilization and will ensure that commonly used items are available on a daily basis. Any instances of flash sterilization will be required to be immediately reported to infection control for review. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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.

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[10] 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 VHA's request, the OIG agreed to follow up on the prior findings during CAP reviews. We reviewed the medical records of 20 patients assessed to be at high risk for suicide and identified the following area that needed improvement.

[10] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Safety Plans. Patients at high risk for suicide are required to receive a copy of the written safety plan.[11] In 8 (40 percent) of the 20 records reviewed, we found that clinicians did not document on the suicide prevention safety plan that patients and/or their families were provided copies of the plan.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires clinicians to consistently document in the electronic medical record that patients at high risk for suicide and/or their families received copies of suicide prevention safety plans.

The VISN and the System Directors agreed with the finding and recommendation. At the time of the OIG CAP visit, the electronic templates used for the documentation of suicide risk, assessment, and the safety plan contained a checkbox item to document that the patient and/or their family received a copy of the suicide prevention safety plan. While the CAP team was still onsite, the template was modified so that the checkbox is required, and the template cannot be completed without documenting that the patient and/or family received a copy of the plan. The corrective actions are acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether the system appropriately coordinated inter-facility transfers and discharges 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 that systems have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the system had an appropriate transfer policy. 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.[12] VHA also requires

[11] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[12] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

systems to monitor and evaluate inter-facility transfers as part of the QM program.

We reviewed transfer documentation for 11 patients transferred from the system's acute inpatient units, emergency departments, or urgent care clinics to other facilities. We found that providers did not document all required information for 8 (73 percent) of the 11 patients. Missing information included informed consent for transfer and advanced directives. In addition, we did not find evidence that the system monitored or evaluated patient transfers as part of the QM program.

Discharges. VHA policy requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions.[13] In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of discharged patients and found deficiencies in 7 (35 percent) of the 20 records. In four records, we found that patients were discharged with special dietary instructions; however, we did not find documentation that the patients or caregivers received education regarding these instructions. In addition, three of the records had discrepancies between the medications listed in the physician's discharge summary and those listed on the written discharge instructions.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires staff to complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.

The VISN and the System Directors agreed with the findings and recommendations. The VISN convened a systems redesign team to review and implement new processes for safe and efficient inter-facility transfers. The group determined that a patient transfer officer position was needed at all VISN sites. The system now has a full-time

[13] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

employee temporarily assigned to work on inter-facility transfers. This employee has implemented a new tracking system. The patient transfer officer position is expected be filled by September 2010.

QM staff will work with clinical applications coordinators to review the discharge summary and discharge instructions templates to ensure that the required elements are included. In addition, documentation consistency will be incorporated into ongoing medical record reviews and will be reported to the Medical Records Committee and the Clinical Executive Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the system maintained a safe and clean health care environment. VHA requires systems to establish comprehensive EOC programs that fully meet VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We reviewed committee meeting minutes, performance monitors, EOC schedules and tracking spreadsheets, fire drill results, and staff training records. We also inspected the following patient care units:

- New York Campus
  - Acute Inpatient Mental Health (two units)
  - Inpatient Medical
  - Medical Intensive Care
  - Dialysis
  - Inpatient Surgical
- Brooklyn Campus
  - Inpatient Medical Surgical
  - Hematology Oncology/Palliative Care
  - Telemetry
  - Dialysis
  - Intensive Care

- St. Albans CLC
  - Long-Term Care (three units)
  - Dementia Care
  - Palliative Care

The system maintained a generally clean and safe environment. Patient safety staff conducted regular fire drills, and clinical staff on the units were knowledgeable of their responsibilities during fire emergencies. The EOC and Infection Control Committees conducted regular meetings and openly exchanged information. Both committees collected and trended patient safety and infection control data and initiated PI activities as appropriate. Furthermore, the system developed risk assessments in compliance with VHA standards. We made no recommendations.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system 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 both MRI areas, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI areas. Patients in the magnet rooms are directly observed at all times. Two-way communication is available between patients and the MRI technologists, and patients have access to a push-button call system while in the scanners. Additionally, the system has conducted fire and medical emergency drills in the MRI areas.

Local policy requires that personnel who have access to the MRI areas receive appropriate MRI safety training. We reviewed the training records of 12 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. In addition, one high-risk patient who had an MRI with contrast media had a signed informed consent prior to

the procedure, in accordance with local policy. We made no recommendations.

Medication Management

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

The system had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoietin-stimulating agents.[14] We found that clinical staff at the New York and Brooklyn campuses had appropriately identified and addressed elevated hemoglobin levels in the 20 patients whose medical records we reviewed. We also found that clinical staff adequately documented influenza vaccinations for CLC residents and followed the established protocol when a delay in receipt of vaccines was experienced. We made no recommendations.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. VHA surveys patients monthly and summarizes the data quarterly. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[15] The target scores are noted on the graphs.

[14] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[15] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

Figure 1:

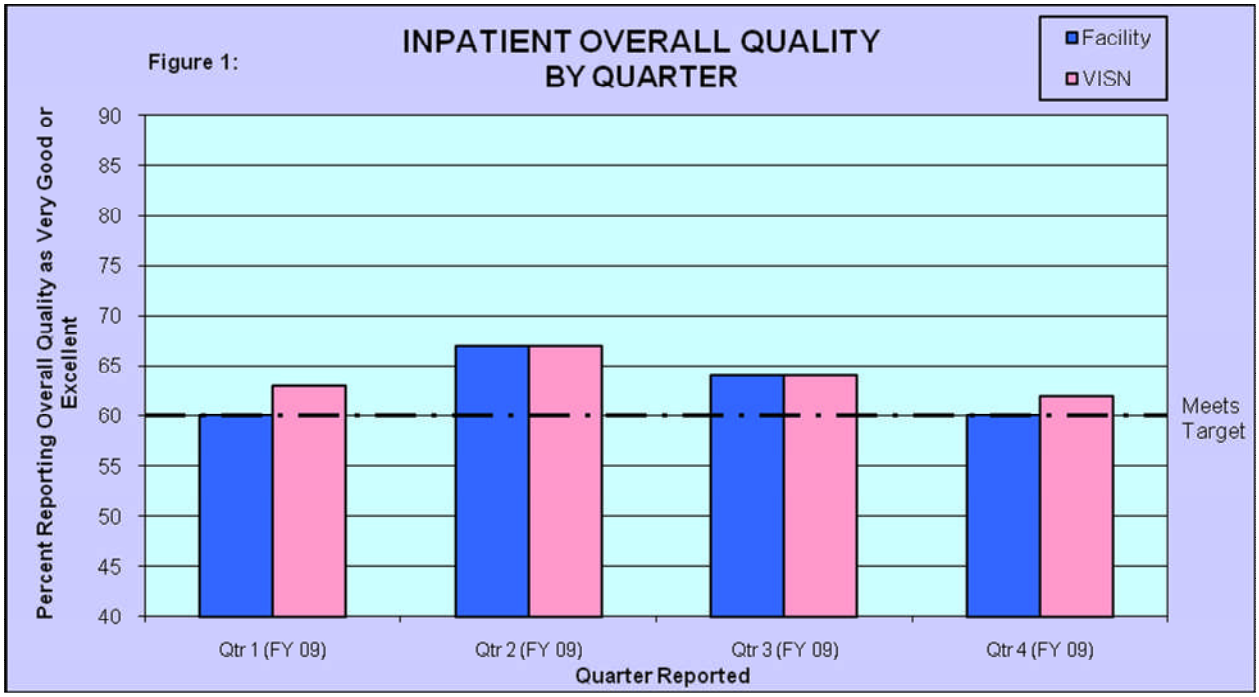
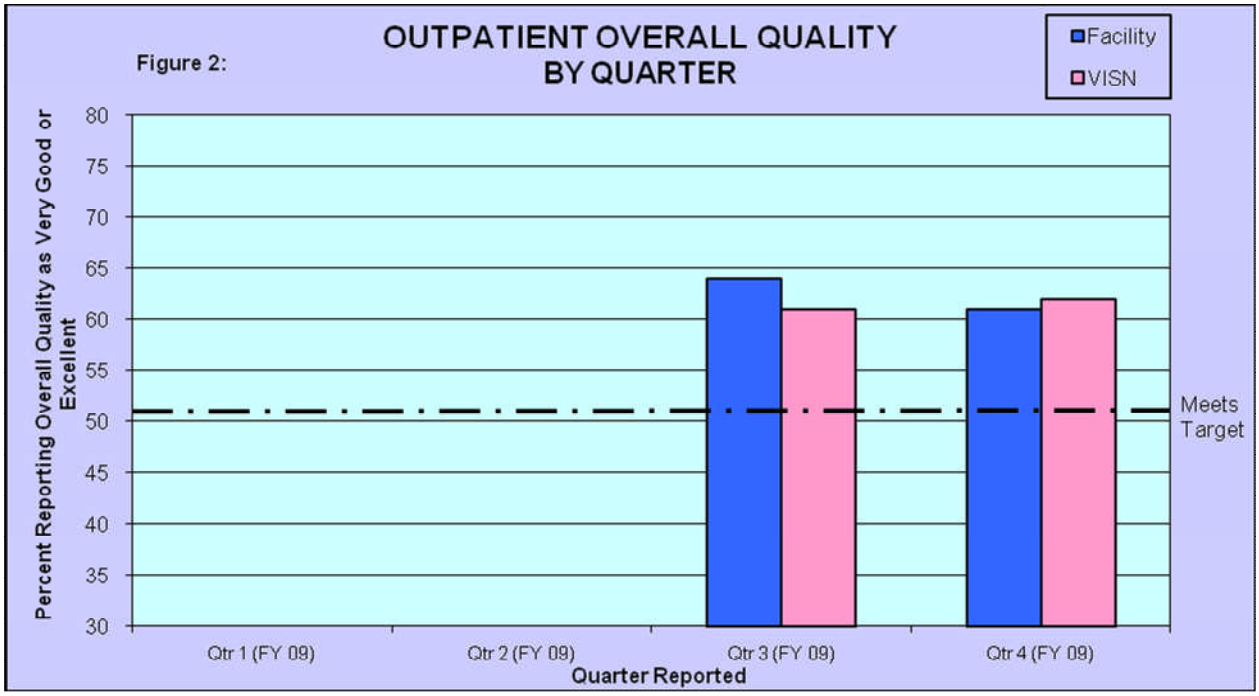
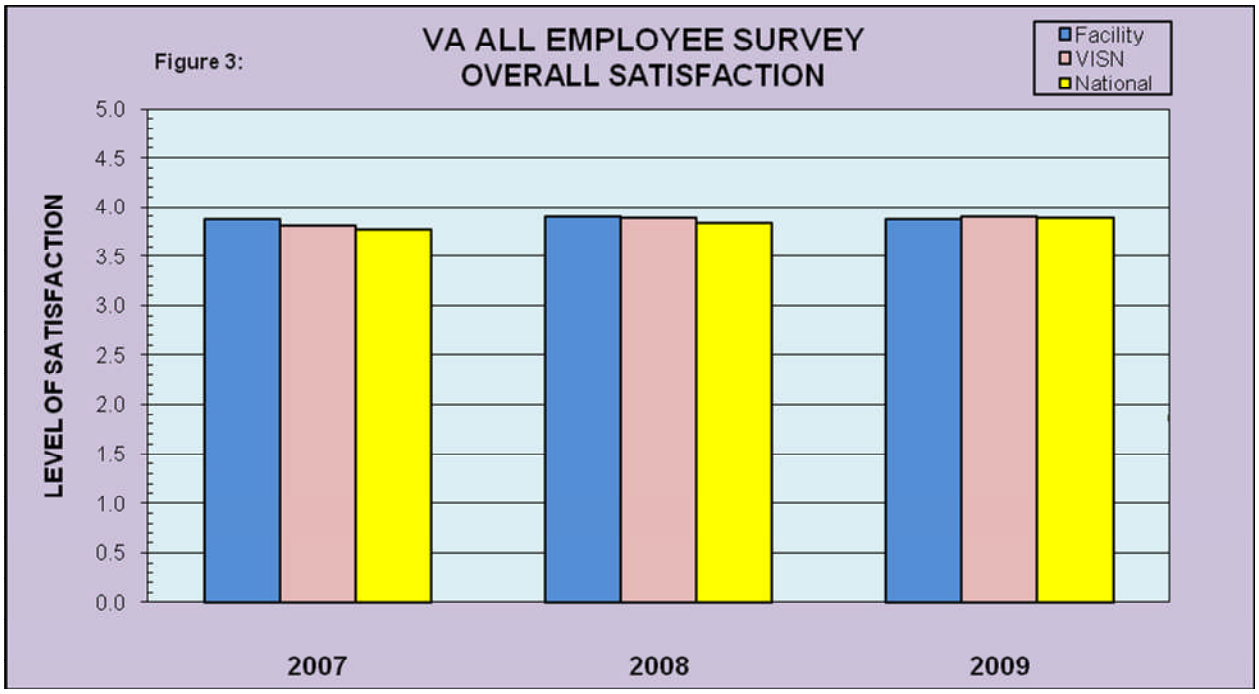


Figure 2:



Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 23, 2010

From: VISN Director

Subj: **Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, NY**

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

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

Attached please find the response to the draft CAP Report for the program review of the VA New York Harbor Healthcare System (VANYHHS).

The VISN concurs with the action plan submitted by the facility.

MICHAEL A. SABO, FACHE

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 23, 2010

From: Acting System Director

Subj: **Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, NY**

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

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

This is to acknowledge receipt and review of the draft CAP report for VA New York Harbor Healthcare System (VANYHHS). Thank you for the opportunity to comment on the recommendations for improvement contained in this report. If you have any questions, please contact Kim Arslanian, the Performance Improvement Manager at (718-630-2865).

MARTINA A. PARAUDA

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 System Director requires managers to trend and analyze outcomes data related to the use of reversal agents in moderate sedation.

Concur

Moderate sedation provided by non anesthesiologist is by opiates in combination with benzodiazepines. Reversals are currently monitored and reported by the different procedural areas (GI, Pulmonary etc). The OIG recommended the trending of these data on an ongoing basis; therefore, the current reporting process will be revised to include all the parameters for monitoring as per VHA Directive 2006-023 Moderate Sedation by Non-Anesthesia Providers. Quality Management will develop a process with Pharmacy Service to report all administrations of reversal agents (narcan and flumazenil) to ensure a comprehensive review. Effective July 12, Pharmacy Service will report all reversal administrations to QM for review. The results of the review will be presented, trended, and reported quarterly to the Operative and Other Invasive Procedures (OOP) Review Committee (Sept, Dec, March, and June). First report to the OOP Committee scheduled for the September 2010 meeting.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that clinical managers fully develop and implement practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting initial privileges or reprivileging.

Concur

VANYHHS staff attended a VISN sponsored workshop presented by the VHA Director of Credentialing and Privileging. The workshop focused on guidelines for developing OPPE and FPPE.

VA NYHHS developed plans for FPPE for newly privileged physicians/providers and/or for granting new privileges for established physicians/providers as well as OPPE for established physicians/providers. These were reviewed and approved by the Professional Standards and Credentialing Board (PS&CB) and the Clinical

Executive Board (CEB). FPPE will be reviewed within 6 months for new providers and semi-annually for all privileged physicians/providers. Minutes of the PS&CB will reflect the review of FPPE and OPPE. Privileges will be granted in accordance with demonstrated competencies. All Service Chiefs were instructed to review and revise current practice evaluations to ensure sufficient provider specific data. Prior to the PS&CB meeting, the credentialing office will review folders to be presented to ensure that any new provider has a completed FPPE. The minutes of the June PS&CB meeting were revised to reflect the detailed discussions of physicians' performance data.

Recommendation 3. We recommended that the VISN Director ensure that the System Director enforce the requirement that new employees receive initial training and that managers validate competencies annually for all pieces of RME.

Concur

A number of meetings were held with personnel involved in RME use and processing. As a component of a recently held RME Stand Down (held on June 2, 2010 and June 8, 2010 and conducted by members of executive senior management, infection control, SPD management, and clinical service chiefs), all personnel folders related to any personnel involved in RME were reviewed. All folders were assessed with respect to competencies, initial training and ongoing training. Additionally, all equipment was reviewed to ensure that comprehensive device-specific SOPs and written manufacturers' instructions for use and processing were in place and current.

All managers of personnel involved in any aspect of RME have been reminded that all personnel who are new to the institution, even if they have transferred from other VA facilities, must undergo complete initial training on all related processes and procedures before they are allowed to perform any duties.

The oversight of RME areas includes the scheduling of a stand-down twice per year. Competencies for each employee are reviewed quarterly. All new employees are given specific training following the approved procedure for the RME they are responsible for cleaning. The competencies and training records are placed in the employee's RME folder with the SOP. These records are reviewed at the stand down as well.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires managers to establish comprehensive device-specific SOPs that are consistent with manufacturers'

recommendations and VHA requirements and ensure that employees follow the SOPs.

Concur

A number of meetings were held with personnel involved in RME use and processing during the first and second week of May. Members of executive senior management, infection control, SPD management, and clinical service chiefs recently held an RME Stand Down on June 2, 2010 and June 8, 2010. A component of the event included a review of all equipment to ensure that comprehensive device-specific SOPs and written manufacturers' instructions for use and processing were in place and current.

An interdisciplinary committee, known as the RME Committee, is fully responsible for reviewing SOPs. No piece of equipment is allowed into service until the committee has approved the SOP and has assured competency training for all associated personnel.

An SOP review subcommittee with membership of the SPD Chief, Infection Control, the Assistant Chief of SPD and other staff as appropriate, was formed in February of 2010. The task of the subcommittee is to review all new RME SOPS and compare them with the manufacturer's instructions and to ensure that the SOP meets all required protocols for disinfection and sterilization. SOPS currently in use will be reviewed annually. The subcommittee meets weekly.

Recommendation 5. We recommended that VISN Director ensure that the System Director requires employees to put on appropriate PPE when entering and remove PPE when leaving decontamination areas.

Concur

All personnel involved in any aspect of RME were required to demonstrate the appropriate use of PPE and all associated policies, procedures were reviewed. It was emphasized that the policies, procedures, and SOPs must be fully implemented at all times. Specifically, PPE in-services were scheduled for all RME areas. 100 percent of all staff was trained by 6/29/10.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires managers to fully implement the system's flash sterilization action plan and restrict flash sterilization use to emergent situations.

Concur

The previously developed flash sterilization plan was implemented on March 1, 2010. The plan was reviewed with the Nurse Managers of the ORs, SPD supervisors, the Chiefs of Surgery, and the nursing staff of both ORs. A walk-through of the process was done with all of the above and it was emphasized that the policy must be followed without exception. Should flash sterilization be needed, it cannot be done without the permission of the Nurse Manager. The Nurse Manager also ensures that commonly used items such as scissors and forceps are available on a daily basis. Since that time, the flash rate has been well below the established threshold. Since some of the previous incidents of flash sterilization were related to scheduling of OR cases, it was reinforced with those involved in scheduling that cases requiring seldom used or loaned equipment must be scheduled well in advance so that flash sterilization is not necessary. It was further emphasized that failure to follow this procedure can result in cancellation of the case. Infection Control and the Surgical Care Line Manager for Nursing Services are receiving monthly written reports and weekly verbal reports on compliance. Any instances of flash sterilization are required to be immediately reported to Infection Control for review. Reports since April of 2010 document zero (0) instances of flash sterilization.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires clinicians to consistently document in the electronic medical record that patients at high risk for suicide and/or their families received copies of suicide prevention safety plans.

Concur

At the time of the OIG-CAP visit, the CPRS templates used for the documentation of suicide risk, assessment and safety plan contained a checkbox item to document that the patient and/or their family received a copy of the suicide prevention safety plan. While still on site, VANYHHS modified the template so that checking the box is required and the template cannot be completed without documenting that the patient and/or family received a copy of the plan.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires staff to complete inter-facility transfer documentation and implement processes to monitor and evaluate transfers.

Concur

The VISN has convened a Systems Redesign team to review and implement new processes for safe and efficient interfacility transfers. The group has met regularly and had determined early in 2010 that in order to ensure proper tracking and monitoring of the completion of Interfacility

notes and consents along with other details such as travel and arrival time and length of stay, a full time point of contact (POC) or patient transfer officer (PTO) was needed at all sites in the VISN. At one site where there are few transfers it is legitimately being treated as a part time position. Currently, two out of the five sites have a full time PTO/POC, one site has a temporary full time person who is developing the program, one site is in the process of selecting an individual and the remaining site is currently considering a full time position for their transfer program.

To date all except one site have implemented the tracking mechanism and three out of the five sites have commenced training of physicians on not only the importance of completing the documents but also where to locate them. Some sites have already shown improvement in obtaining correct documents on transfers as required per Directive 2007–015.

VA New York Harbor has a full time employee temporarily assigned to work on Interfacility transfers. This person has implemented the new tracking system as well as other daily communication processes. The tracking mechanism includes collecting data on time of transfer, consent and transfer note obtained, and days in hospital before transfer back or to home. We are currently writing a position description for the position to be announced internally. It is hoped that the position will be filled by September 2010.

VA New York has taken the lead on communicating regularly with other VISN 3 sites on individual transfers. In addition we are developing communication links with a VISN 4 hospital from which we receive a high number of transfers. Recently we began conference calls with the other sites to compare information on our tracking sheets to verify accuracy and resolve issues.

We have begun training physicians at various venues such as the Clinical Service Chief meeting and the Executive Staff meeting. We have also discussed at VISN Neurosurgery meetings. We plan to implement training at other venues as well when our data indicates areas in need.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that discharge summaries and discharge instructions include all required elements and that information in the summaries and instructions is consistent.

Concur

Quality Management staff will work with the Clinical Applications Coordinators to review the discharge summaries and discharge instructions CPRS templates to ensure the required elements are included. In addition, the consistency of the documentation will be

incorporated into the ongoing medical record reviews and reported to the Medical Records Committee and Clinical Executive Board. Target implementation date: September 1, 2010.

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