Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00473-230

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

August 23, 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
CLC	community living center
DRRTP	Domiciliary Residential Rehabilitation Treatment Program
EOC	environment of care
facility	Bath VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
ICU	intensive care unit
ISO	Information Security Officer
JC	Joint Commission
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
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 Bath VA Medical Center, Bath, New York

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 June, 14, 2010.

Review Results: The review covered seven activities. We made no recommendations for the following activities:

- Medication Management
- Suicide Prevention Safety Plans

The facility's reported accomplishment was the institution of a comprehensive quality management dashboard. The dashboard is coordinated by a data analyst, allowing for aggregation of facility-wide data. As a result, all senior managers are able to access centralized data for monitoring and comparison.

Recommendations: We made recommendations in the following five activities:

Quality Management: Develop a local policy governing clinical staff Advanced Cardiac Life Support and Basic Life Support training, and develop an action plan to ensure timely renewal of all certifications.

Physician Credentialing and Privileging: Fully develop professional practice evaluations for all physicians, and ensure that Professional Standards Board meeting minutes reflect discussions regarding performance data.

Reusable Medical Equipment: Revise dental standard operating procedures to be consistent with manufacturers' guidelines. Ensure that employees responsible for reprocessing reusable medical equipment follow the standard operating procedures. Require Engineering Service to inspect air filters quarterly in Supply, Processing, and Distribution areas and to document the inspections.

Coordination of Care: Provide guidance to facility staff on using VA's "Inter-Facility Transfer Form," and monitor compliance. Implement procedures to ensure that patients' dietary needs are correctly and consistently recorded in all discharge documentation.

Environment of Care: Ensure that the Information Security Officer attends environment of care rounds.

Comments: The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment 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 seven activities:

- Coordination of Care
- EOC
- Medication Management
- 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 the recommendation from our prior CAP review of the facility (*Combined Assessment Program Review of the Bath VA Medical Center, Bath, New York,*

Report No. 07-00127-52, January 2, 2007). The facility had corrected the finding from that review.

During this review, we also presented crime awareness briefings to 117 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 Accomplishment

QM Dashboard

In 2008, upon receipt of a new VHA QM directive, the QM Manager met with the facility Director and outlined her vision for developing a comprehensive database that would consolidate all documentation to support program requirements. The QM Manager began work with the data analyst to move the process forward.

The QM dashboard was created in the 1st quarter of FY 2009, and the local Leadership Committee was educated on the directive requirements and the methodology that would be used to ensure compliance. The local Leadership Committee embraced the dashboard concept with overwhelming approval. The QM Manager and the data analyst began educating facility staff and consolidating supporting documents. Facility managers use this tool as a guidepost for managing the facility's quality improvement program.

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 one area that needed improvement.

Life Support Training. VHA policy requires the implementation of a system to monitor ACLS and BLS training and requires an action plan to ensure timely renewal of all certifications.[1] At the time of our review, a local policy was in development but was not in place. As a result, we were unable to determine which staff members were required to maintain ACLS or BLS certification and whether their certifications were current.

Recommendation

1. We recommended that local policy address clinical staff ACLS and BLS training and that an action plan be developed to ensure timely renewal of all certifications.

Physician C&P

The purpose of this review was to determine whether the facility 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 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.[3] However, we identified the following area that needed improvement.

Professional Practice Evaluations. VHA policy requires specific competency criteria for FPPE and OPPE for all privileged physicians. Although clinical managers had developed service-specific criteria for practice evaluations, at the time of our review, full implementation was not in place for all physicians. As a result, we did not find FPPEs for two of the three physicians who required them. One physician had requested additional privileges, and one was recently hired. In addition, we did not find sufficient measurable performance data to support reprivileging in six of the seven OPPEs for the 2 previous quarterly periods. Furthermore, PSB meeting minutes did not reflect detailed discussions of

[1] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[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 reported by an individual health care practitioner.

physicians' performance data prior to granting privileges or reprivileging, as required by VHA policy.

Recommendation

2. We recommended that clinical managers fully develop professional practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data 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. 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 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 SPD areas plus equipment in the ICU, one CLC unit, and the cardiology clinic. We also observed the reprocessing of equipment items we selected from a list provided by the facility. We determined that the facility had established appropriate guidelines for reprocessing RME. However, we identified the following areas that needed improvement.

SOPs. VHA requires SOPs for all pieces of RME to be current and consistent with manufacturers' guidelines.[4] During our inspection of the SPD decontamination area, we noted that SOPs were present for staff reference. We reviewed the SOPs for four pieces of dental RME and observed reprocessing of the pieces to determine whether reprocessing was being conducted in accordance with the facility's SOPs. We found that SOPs were not consistent with the manufacturers' guidelines.

VHA requires that employees are trained according to device-specific SOPs in order to ensure proper high-level disinfection.[5] We found the SOP for the transrectal biopsy probe to be current and consistent with the manufacturer's guidelines. However, the employee we observed

[4] VHA Directive 2009–004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[5] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

reprocessing the probe did not follow the procedural steps indicated by the SOP.

Air Flow. VA requires that Engineering Service inspect air filters in the SPD areas at least quarterly.[6] Facility managers could not provide documentation that air filters were inspected in calendar year 2009.

Recommendations

3. We recommended that facility managers revise the dental SOPs to ensure consistency with manufacturers' guidelines.

4. We recommended that employees responsible for reprocessing RME follow the SOPs.

5. We recommended that Engineering Service inspect air filters quarterly in all SPD areas and document these inspections.

Coordination of Care

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 that facilities have policies that ensure the safe, appropriate, and timely transfer of patients. We found that the facility had recently implemented a process to monitor and evaluate inter-facility transfers, as required by VHA policy. This process included a retrospective review of transfers as well as a checklist for unit staff to use. The facility also had a policy addressing discharge planning, and our review of discharge documentation for 14 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.[7] VHA also requires inter-facility transfers to be monitored and evaluated as part

[6] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements;* August 16, 2002.
[7] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

of the QM program using VA Form 10-2649A, "Inter-Facility Transfer Form," or an electronic equivalent.

We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient unit to other facilities. We found that for all 10 patients, providers did not use the "Inter-Facility Transfer Form" or an equivalent. Instead, specific details about the transfers were documented in various places in the medical records. For 2 (20 percent) of the 10 patients, providers prepared "Transfer Summaries;" however, these summaries did not contain all required information, such as level of care needed or medical requirements during transportation. 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.

Discharges. VHA policy requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions.[8] In addition, The JC requires that clinicians provide patients with written discharge instructions. We reviewed the medical records of 14 patients discharged in February and March 2010 and found that for 2 patients (14 percent) the discharge instructions were not consistent with the dietary orders. In addition, for 4 (29 percent) of the 14 patients, we found that other discharge documentation, such as discharge summaries or nursing discharge and patient education notes, contained inconsistent dietary information. As a result, it was not clear whether these patients received consistent dietary information prior to discharge.

Recommendations

6. We recommended that facility managers issue guidance to providers on using VA Form 10-2649A, "Inter-Facility Transfer Form," (or its electronic equivalent) for documenting all inter-facility transfers and monitor compliance with the documentation requirement.

7. We recommended that facility managers implement procedures to ensure that patients' dietary needs are correctly and consistently recorded in all discharge documentation.

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

EOC

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

We inspected the ICU, the medical unit, the emergency department, the dental clinic, the specialty clinics area, the domiciliary, and three CLC units. The facility maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

EOC Rounds. VHA recommends that EOC rounds be conducted weekly, and in an effort to focus on improving information security, the facility ISO is to be included.[9] The facility maintained detailed records of EOC rounds, including attendance, prioritization, and follow-up of deficiencies. However, the ISO attended weekly EOC rounds on only three occasions from October 1, 2009, through March 30, 2010.

Recommendation

8. We recommended that the facility ISO attend EOC rounds.

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 erythropoiesis-stimulating agents.[10] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced.

Also, although the pharmacy is closed from 8:30 p.m. to 8:00 a.m. on weekdays and from 4:30 p.m. to 8:00 a.m. on

[9] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[10] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

weekends, we found that the facility had appropriately provided a qualified pharmacist to answer questions during those hours and had an adequate review process. 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 medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. 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 C and D, pages 11–15 for the full text of the Directors' comments.) We consider Recommendation 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

[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.

Facility Profile[13]		
Type of Organization	Rural medical center	
Complexity Level	3	
VISN	2	
CBOCs	Elmira, NY Wellsville, NY	
Veteran Population in Catchment Area	30,000	
Type and Number of Total Operating Beds: • **Hospital**	20	
• **CLC**	160	
• **Other**	220 DRRTP	
Medical School Affiliation(s)	None	
• **Number of Residents**	0	
	Current FY	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$79.8	$80.3
• **Medical Care Expenditures**		$80
Total Medical Care FTE	671	683
Workload:		
• **Number of Unique Patients**		12,223
• **Inpatient Days of Care:**		
o **Acute Care**		3,897
o **CLC**		41,918
Hospital Discharges		1,087
Total Average Daily Census (including all bed types)		307
Cumulative Occupancy Rate		71.4%
Outpatient Visits		135,490

[13] All data provided by facility management.

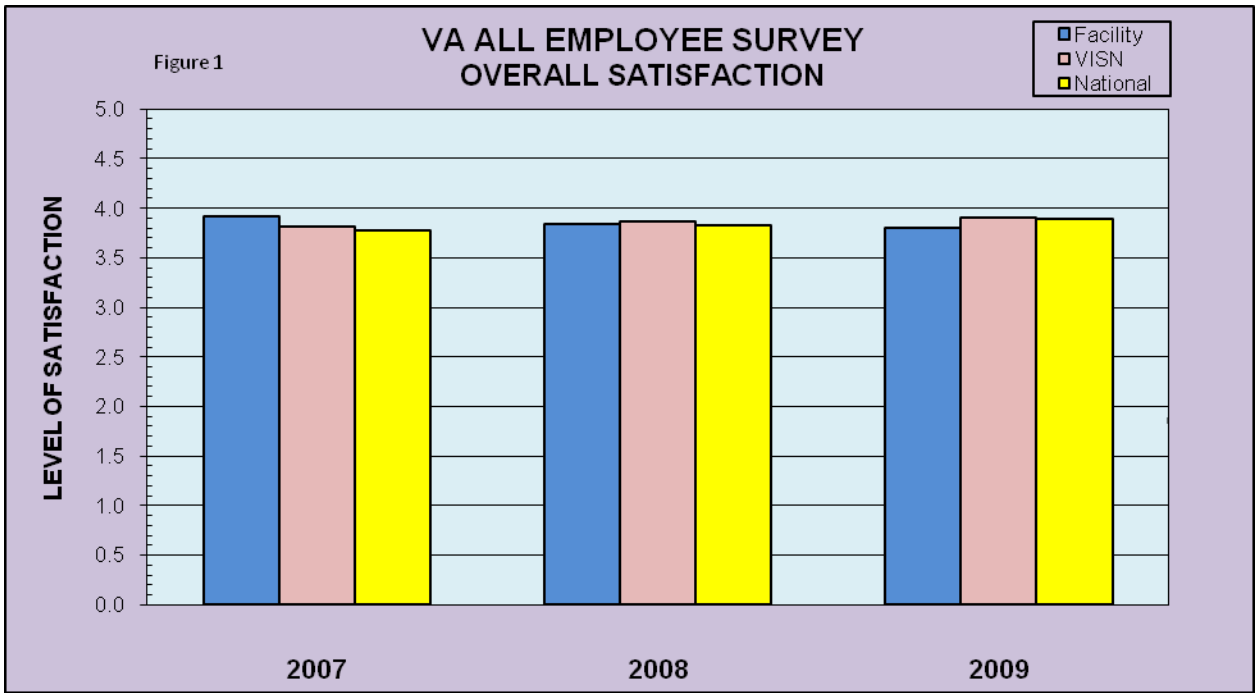
VHA Satisfaction Surveys

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 the facility's and VISN's calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall outpatient satisfaction scores and targets for the 1st quarter of FY 2010.

Table 1

	FY 2009		FY 2010
	Inpatient Score	Outpatient Score	Outpatient Score 1st Quarter
Facility	67.28	43.58	58.3 (target 56)
VISN	61.80	59.03	59.1 (target 56)

Employees are surveyed annually. Figure 1 below shows the facility'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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 15, 2010

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

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

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

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

I have reviewed the findings contained in the subject Combined Assessment Program Review conducted the week of June 14, 2010. I concur with the facility action plans to resolve the identified findings.

For STEPHEN L. LEMONS, Ed.D.

Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 15, 2010

From: Director, Bath VA Medical Center (528A6/00)

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

To: Network Director, VISN 2 (10N2)

Review of the findings contained in the subject Combined Assessment Program Review conducted during the week of June 14, 2010 has been completed. We concur with the findings noted therein, and submit for your review and approval our recommendations to resolve the identified findings.

for David J. West
Medical Center Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that local policy address clinical staff ACLS and BLS training and that an action plan be developed to ensure timely renewal of all certifications.

Concur with Recommendation.

Target date for completion: 7/30/10

Facility Response: Medical Center Policy has been developed that identifies clinical staff requiring ACLS and BLS training. The policy also addresses renewal of certification requirements.

Recommendation 2. We recommended that clinical managers fully develop professional practice evaluations for all physicians and that PSB meeting minutes reflect discussions regarding performance data prior to granting requested privileges or reprivileging.

Concur with Recommendation.

Target date for completion: 7/30/10

Facility Response: Professional Practice Evaluation forms are being revised. PSB minutes have been enhanced to include discussion regarding performance data prior to granting requested privileges or reprivileging.

Recommendation 3. We recommended that facility managers revise the dental SOPs to ensure consistency with manufacturers' guidelines.

Concur with Recommendation.

Target date for completion: Completed 6/18/10

Facility Response: There were four RME devices reviewed.

The four Dental SOPs that were identified were corrected to ensure that manufacturer's guidelines matched the SOPs. This was accomplished during the OIG CAP visit.

One of the Dental SOPs was for a device that utilized generic sterile processing guidelines; the surveyor recommended implementation of the specific manufacturer's guidelines; this was accomplished during the OIG CAP visit.

One Dental SOP was for cleaning of reusable burrs housed in an aluminum dental burr block. The VAMC totally transitioned to disposable dental burrs on February 1, 2010 and discarding of burrs after single use. However, the facility had not updated this SOP at the time of the June 14–18, 2010 CAP visit to reflect the change to disposable burrs and discard after single use. The surveyor recommended the SOP be pulled which was accomplished during the OIG CAP visit. The SOP was updated and provided to the surveyors at the time of the visit.

Recommendation 4. We recommended that employees responsible for reprocessing RME follow the SOPs.

Concur with Recommendation.

Target date for completion: 8/16/10

Facility Response: The surveyor selected an SOP for a piece of equipment (trans rectal biopsy probe) which had not been used since 1/29/09. Competencies were completed for staff in May 2010. The staff was unable to demonstrate accurate cleaning of the equipment. The facility made a decision to pull the trans rectal biopsy probe device until the process of re-education has been completed.

Re-education of employees involved in the use and reprocessing of RME includes locating, reading and following steps of RME SOPs as cleaning is performed to ensure SOPs are followed as required by VHA Policy.

Recommendation 5. We recommended that Engineering Service inspect air filters quarterly in all SPD areas and document these inspections.

Concur with Recommendation.

Target date for completion: Completed 6/18/10

Facility Response: A process to ensure that air filters in SPD areas are inspected quarterly and replaced as necessary has been implemented. Supporting documentation is maintained in Engineering Service and the office of the Chief of SPD.

Recommendation 6. We recommended that facility managers issue guidance to providers on using VA Form 10-2649A, "Inter-Facility Transfer Form," (or its electronic equivalent) for documenting all inter-facility transfers and monitor compliance with the documentation requirement.

Concur with Recommendation.

Target date for completion: 8/12/10

Facility Response: Health Information Management Services has developed an educational presentation on use of the electronic Inter-facility Transfer Note. This will be presented to Medical staff. 100 percent review of all patient transfers are monitored

for compliance with documentation requirements by the Quality Management department.

Recommendation 7. We recommended that facility managers implement procedures to ensure that patients' dietary needs are correctly and consistently recorded in all discharge documentation.

Concur with Recommendation

Target date for completion: Completed 6/21/10

Facility Response: A process was implemented whereby the most recent diet order is automatically imported into Provider Discharge Instructions. Dietary discharge documentation will be monitored and reported through the Health Information and Analysis Council.

Recommendation 8. We recommended that the facility ISO attend EOC rounds.

Concur with Recommendation.

Target date for completion: Completed 6/18/10

Facility Response: Facility ISO is now attending EOC rounds. Evidence of attendance is monitored through EOC attendance roster.

OIG Contact and Staff Acknowledgments

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