Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No.10-00475-38

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

November 30, 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

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CCT	Community Care Team
CDC	Centers for Disease Control and Prevention
CLC	community living center
COC	coordination of care
CRC	community residential care
EOC	environment of care
facility	Canandaigua VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRC	Peer Review Committee
PRRT	psychosocial residential rehabilitation treatment
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
WHO	World Health Organization

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Executive Summary: Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, 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 September 13, 2010.

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

- Environment of Care
- Medication Management
- Physician Credentialing and Privileging
- Reusable Medical Equipment

The facility's reported accomplishments were the community care team and the Sky Art Project. The community care team connects veterans residing in residential care homes or living independently to services across the continuum of care. The Sky Art Project decreases the clinical appearance of the environment for hospice patients.

Recommendations: We made recommendations in the following three activities:

Suicide Prevention Safety Plans: Require clinicians to ensure that all patients at high risk for suicide receive timely, comprehensive safety plans and to document in the medical records that patients and/or their families received copies of the plans.

Quality Management: Require the peer review coordinator to submit written notification for all completed Level 2 and Level 3 peer reviews to the Peer Review Committee. Ensure facility managers submit all required data reports to senior management.

Coordination of Care: Require clinicians to document in the patient medical records that they provided patients and/or their families with written discharge instructions.

Comments

The interim Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- COC
- EOC
- Medication Management
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through June 30, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 07-00578-164,

July 10, 2007). The facility had corrected all findings from that review.

During this review, we also presented crime awareness briefings for 221 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Reported Accomplishments

CCT

The CCT was established in July 2007 in response to changes in services provided by the facility. Changes included shifting acute MH care to other VISN 2 facilities and decreasing care homes involved in the VA-approved CRC home program. In addition, veterans living independently in the community or living in CRC homes not approved by the VA did not receive case management services. Furthermore, non-VA approved CRC home sponsors did not have access to educational opportunities that existed for staff in VA-approved CRC homes.

The CCT serves as a liaison by connecting veterans to services across the continuum of care. Depending on the clinical needs of the veteran, the CCT may connect veterans to services provided by the VA or to non-VA services. One goal of the CCT is to ensure continuity of care for seriously mentally ill veterans. CCT members also serve as points of contact to residential care home sponsors to discuss veterans' medical needs.

Because of ongoing CCT services, staff have reported a decrease in missed clinical appointments, an improvement in continuity of care, a reduction in hospitalization, and an increase in educational opportunities for caregivers.

Sky Art Project

Toward the end-of-life journey, hospice patients inevitably spend increasing amounts of time lying in a hospital bed, so staff started the Sky Art Project as a way to decrease the clinical appearance of the ceilings over patients' beds.

With art teacher guidance, local primary school students painted ceiling tiles bursting with color, design, and

imagination. Patients choose where they would like the tiles to be located. The art infuses an intergenerational aspect into the unit culture, and patients enjoy an aesthetically pleasing view. In addition, staff can easily move tiles from area to area. The cost benefit ratio is significant as the project has a major impact on patients at little cost to the facility.

The project is a collaborative process involving nursing, staff liaisons to participating schools, engineering, safety, the Fire Department, facility leadership, and the community. The plan is to expand the project and offer the art to less ambulatory patients, to those who are cognitively impaired, and eventually, to all of the patients on the unit. There may also be an opportunity to expand the project to the Rochester CBOC.

Results

Review Activities With 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.[1]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[2] 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.

Because many facility patients receive acute MH services at other facilities, providers at those facilities frequently initiate

[1] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[2] *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 then receive their follow-up MH care at the facility. Facility staff told us that if providers at other facilities did not complete safety plans, outpatient providers at the facility completed them during the first outpatient MH visit.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide, all of whom received acute MH services at other facilities. We found deficiencies in six (60 percent) of the records. These deficiencies were not corrected during follow-up visits at the facility. One of the records did not include a safety plan, and four of the records did not include documentation that patients and/or their families received copies of the plans. For the last record, development of the plan was not timely. Despite the fact that staff flagged the record three times in a 12-month period to indicate the patient was at high risk for suicide, a safety plan was not developed until the patient record was flagged a fourth time.

Recommendation

1. We recommended that clinicians ensure that all patients at high risk for suicide receive timely, comprehensive safety plans and that they document in the medical records that the patients and/or their families received copies of plans.

QM

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

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

Peer Review. VHA policy requires that the supervisors of individuals being peer reviewed submit written notifications of completed actions on all Level 2 and Level 3 peer reviews to the PRC.[3] Although supervisors submitted completed

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

actions to the peer review coordinator, the coordinator did not submit the completed actions to the PRC for review.

Data Analysis. VHA policy requires that data be collected, analyzed, trended, and reported to senior management.[4] Our review of data reports and committee minutes found that managers collected, analyzed, and trended appropriate data. However, we did not find evidence that managers submitted patient complaint data and adverse event disclosure data to senior management.

Recommendations

2. We recommended that the peer review coordinator ensure that written notification of all completed Level 2 and Level 3 peer reviews is submitted to the PRC for review.

3. We recommended that facility managers ensure that all required data reports are submitted to senior management.

COC

The purpose of this review was to evaluate whether discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 25 discharged patients and determined that clinicians had generally documented the required elements. We also found that the facility had an interdisciplinary discharge planning process that facility staff initiated upon patients' admissions to the CLC and domiciliary and that facility staff actively engaged patients and their family members in discharge planning. However, we identified one compliance issue during our review.

Receipt of Discharge Instructions. VHA policy[5] and JC standards also require that clinicians provide patients with written discharge instructions and that patient records indicate that instructions are given to patients or their designees. We found that 14 (56 percent) of the 25 records did not include documentation that patients or their designees received written discharge instructions.

[4] VHA Directive 2009-043, *Quality Management System,* September 11, 2009.
[5] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.

Recommendation

4. We recommended that facility managers implement procedures to ensure that clinicians document in patient medical records that patients and/or their families received written discharge instructions.

Review Activities Without Recommendations

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 a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We conducted inspections of the geriatric psychiatry unit, the dementia unit, and two CLC units. We also inspected a primary care clinic, the dental clinic, the adult day care center and outpatient geriatric clinic, the addiction program clinic, a residential rehabilitation program, and the domiciliary. The facility maintained a generally clean and safe environment. In general, nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units.

Equipment and surfaces in patient care areas must be clean and in good repair to reduce the spread of infections. In three of the areas inspected, we found wheelchairs with torn coverings or loose armrests. Also, in one area, we found soiled wheelchairs returned to clean storage. Staff addressed these issues while we were onsite. Therefore, we did not make a recommendation for these findings.

The JC, the CDC, and the WHO recommend that health care facilities develop a comprehensive IC program with a hand hygiene component that includes monitors, data analysis, and provider feedback. Local policy identified hand hygiene as a monitoring activity. We reviewed hand hygiene data from 23 clinical areas for quarter 4 of FY 2009 and for quarters 1–3 of FY 2010. In two areas, we found no data for quarters 2 and 3 of FY 2010. Facility staff told us that there was a change in personnel and that staff misunderstood the need to collect hand hygiene data in these areas. Facility managers provided an action plan. Therefore, we made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed a medication management process for CLC residents.

Nursing staff documented the administration of influenza vaccinations adequately for CLC residents, and clinical staff followed the established protocol when the facility experienced a delay in the receipt of vaccines. Although the pharmacy is closed from 6:00 p.m. to 8:00 a.m. Monday through Friday and from 4:30 p.m. to 8:00 a.m. Saturday and Sunday, a qualified pharmacist is available to answer questions during those hours. We made no recommendations.

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 physician profiles.[6] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 11 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. FPPEs were appropriately implemented for newly hired physicians. Service-specific criteria for OPPEs had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining a safe environment. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD. Engineering managers monitored and maintained air exchanges and air pressure in the

[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

decontamination and clean areas of SPD. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. In addition, the facility had a process in place to track RME should a sterilization failure occur.

For 25 pieces of dental RME, we reviewed the SOPs for reprocessing. In general, we found the SOPs to be current and consistent with the manufacturers' instructions. For three pieces of critical dental RME, employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies and training were current and consistently documented. We made no recommendations.

Comments

The interim VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[7]		
Type of Organization	Medical center	
Complexity Level	3	
VISN	2	
CBOC(s)	Rochester, NY	
Veteran Population in Catchment Area	67,450	
Type and Number of Total Operating Beds:		
• **CLC**	138	
• **Other**	Domiciliary – 25 Homeless domiciliary – 25 PRRT – 30	
Medical School Affiliation(s)	University of Rochester	
• **Number of Residents**	150	
	Current FY (through quarter 3)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$108	$99.7
• **Medical Care Expenditures**	$74.8	$96
Total Medical Care FTE	816.1	824.9
Workload:		
• **Number of Station Level Unique Patients**	17,644	17,443
• **Inpatient Days of Care:**		
o **Acute Care**	0	0
o **CLC/Nursing Home Care Unit**	30,409	39,897
Hospital Discharges	364	681
Total Average Daily Census (including all bed types)	171.2	177.2
Cumulative Occupancy Rate	78.3%	81.3%
Outpatient Visits	180,775	271,199

[7] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. VISN policy governing violent behavior should comply with VHA policy.	Current policy is in compliance.	Y	N
2. Facility policy governing violent behavior should comply with VHA policy.	Current policy is in compliance.	Y	N
3. Category I Patient Record Flag advisories need to be flagged appropriately.	Policy changes required implementation of appropriate patient flagging procedures.	Y	N
4. Medical emergency data should be trended and reported to an appropriate monitoring committee.	Data is appropriately trended and reported.	Y	N
EOC			
5. Dental Service employees need to monitor refrigerator temperatures and medication expiration dates.	Monthly oversight monitoring process reported through the medical care line.	Y	N
6. Managers need to obtain municipal water quality data reports.	Facility managers acquire and analyze quarterly municipal water quality testing data.	Y	N

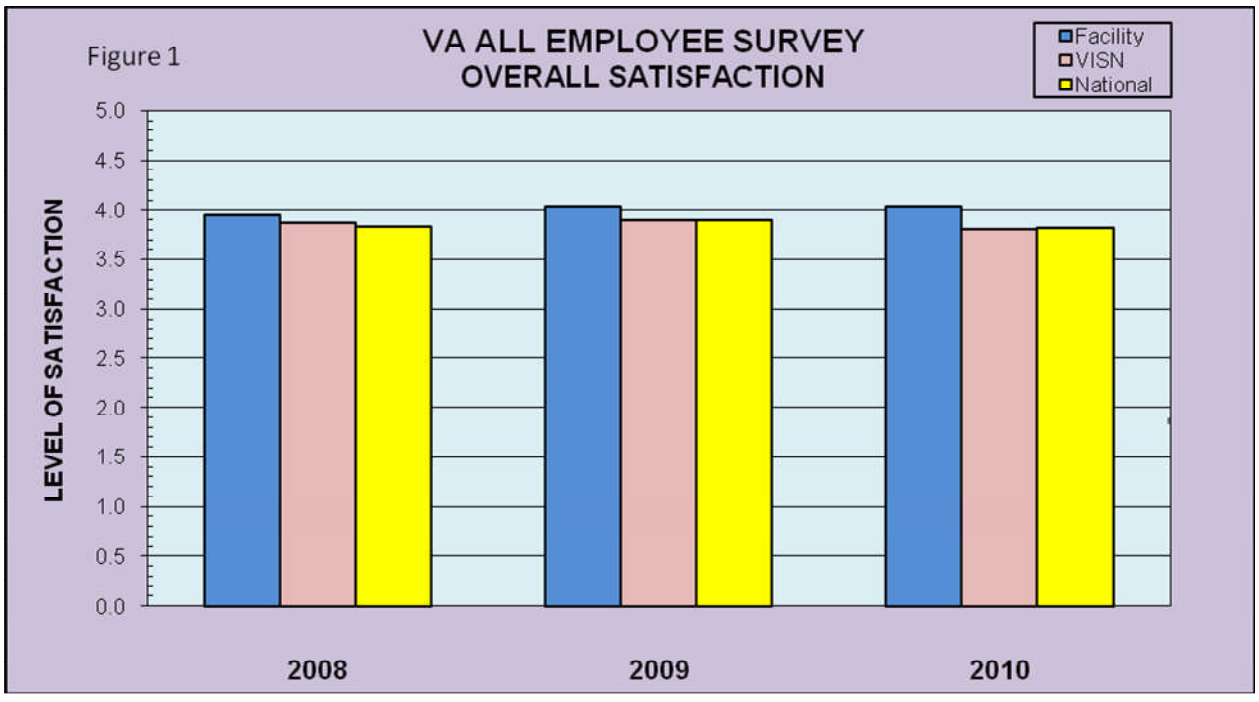
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.[8]

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	NA	57.97	NA	NA	53.8	58.4
VISN	67.28	59.03	58.2	67.0	59.1	57.9
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



[8] Facility inpatient overall quality is not included because this facility does not provide inpatient services.

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 28, 2010

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

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

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

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

1. Attached is the response from the VA Medical Center Canandaigua, New York to the draft report from the Combined Assessment Program Review conducted at that facility September 13–16, 2010.

2. The medical center carefully reviewed all items identified as opportunities for improvement and has concurred in all the recommendations that were made. The Network concurs with the recommendations contained in the report.

3. If you have any questions or need additional information, please contact Paula LeGrett, Performance Manager, at (585) 393-7573.

David J. West, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 28, 2010

From: Director, Canandaigua VA Medical Center (528A5/00)

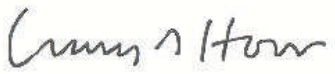
Subj: **CAP Review of the Canandaigua VA Medical Center, Canandaigua, NY**

To: Interim Network Director, VA Healthcare Upstate New York (10ND2)

1. The Department of Veterans Affairs Medical Center at Canandaigua, New York was inspected by the Office of Inspector General's CAP Review Team from September 13 through September 16, 2010. The inspection was conducted in a thorough and professional manner.

2. After reviewing the draft IG/CAP Review Report, VAMC Canandaigua concurs with the CAP Review Team's findings. The corrective actions and their target dates for completion are set forth in the action plans.

3. If you have any questions or need additional information, please contact Paula LeGrett, Performance Manager, at (585) 393-7573.



Craig S. Howard

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 clinicians ensure that all patients at high risk for suicide receive timely, comprehensive safety plans and that they document in the medical records that the patients and/or their families received copies of plans.

Concur Target date for completion: 10/1/2010

Suicide Prevention Coordinator implemented a monthly oversight monitoring process to ensure that all patients at high risk for suicide receive timely, comprehensive safety plans and document in medical records that patients and/or their families received copies of plans. Monthly reports are submitted to Behavioral Health Leadership through the quarterly report to the Quality Retreat. Tracking tool developed related to all four recommendations by Performance Management to monitor compliance.

Recommendation 2. We recommended that the peer review coordinator ensure that written notification of all completed Level 2 and Level 3 peer reviews is submitted to the PRC for review.

Concur Target date for completion: 10/7/2010

Peer Review Coordinator implemented a written notification process of all completed actions on Level 2 and Level 3 peer reviews to the Peer Review Committee. Quarterly reports to monitor compliance are submitted through the Executive Committee of the Medical Staff. Tracking tool developed related to all four recommendations by Performance Management to monitor compliance.

Recommendation 3. We recommended that facility managers ensure that all required data reports are submitted to senior management.

Concur Target date for completion: 10/1/2010

Senior Leadership implemented a quarterly Quality Retreat to ensure Facility Managers submit all required data to Senior Management. Quarterly reports are submitted to Senior Leadership through the Quality Retreat. Tracking tool developed related to all four recommendations by Performance Management to monitor compliance.

Recommendation 4. We recommended that facility managers implement procedures to ensure that clinicians document in patient medical records that patients and/or their families received written discharge instructions.

Concur Target date for completion: 10/27/2010

Behavioral Health and Geriatrics Care Lines implemented a required template field that ensures the Clinician's document in patient medical records that patients and/or their families received written discharge instructions. Quarterly reports to monitor compliance are submitted to Senior Leadership through the Quality Retreat. Tracking tool developed related to all four recommendations by Performance Management to monitor compliance.

OIG Contact and Staff Acknowledgments

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