Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01336-235

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

August 1, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Bath VA Medical Center
FY	fiscal year
HF	heart failure
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
OIG	Office of Inspector General
POCT	point-of-care testing
PUMA	physician utilization management advisor
QM	quality management
RCA	root cause analysis
UM	utilization management
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, 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 May 7, 2012.

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

- Colorectal Cancer Screening
- Coordination of Care
- Medication Management

The facility's reported accomplishments were receiving the Gold Cornerstone award from the National Center for Patient Safety in 2011 and identifying a previously unrecognized look-alike/sound-alike medication pair.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Ensure environmental deficiencies in the Mental Health Residential Rehabilitation Treatment Program are reported in Environment of Care Committee minutes and tracked to resolution and closure. Require the program's residential environment to be clean and safe and to have closed circuit television monitoring at all access points. Conduct a risk assessment to determine how overall security measures can be strengthened at entry and exit points.

Quality Management: Ensure that the Director is added as a member of the Quality Management Council and that the physician utilization management advisor responds to, collaborates on, and makes medical recommendations for all referred cases.

Nurse Staffing: Ensure facility nursing leadership develops and implements a nurse staffing methodology.

Polytrauma: Ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients and that the plans contain all required elements.

Point-of-Care Testing: Require employees who perform glucose point-of-care testing to have competency assessed at the required intervals. Ensure that staff complete and document the elements required in response to critical test results and that compliance is monitored.

Comments

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

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

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

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

- COC
- CRC Screening
- EOC
- Medication Management
- Nurse Staffing
- POCT
- Polytrauma
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through April 30, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Bath VA Medical Center, Bath, New York,* Report No. 10-00473-230, August 23, 2010).

During this review, we also presented crime awareness briefings for 131 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 104 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Gold Cornerstone Award

The facility received the Gold Cornerstone Award for 2011 from the National Center for Patient Safety for the quantity, quality, and timeliness of RCAs. The goal of the cornerstone program is to enhance the RCA process and to recognize leaders in patient safety. In order to receive this award, facility managers had to complete more than eight timely RCAs with strong strings,[1] complete at least one additional RCA of the facility's choice, complete all of the reviews within 45 days, and report all of the outcome measures due in the current and past FYs by October 15th of the following FY.

Look-Alike/Sound-Alike Alert

While completing internal safety reviews, facility staff identified a potential look-alike/sound-alike medication pair that was not previously recognized by the Institute for Safe Medication Practices. Look-alike/sound-alike medications have names that sound or are spelled similarly and can lead to an increased risk of medication error. Diazepam and diltiazem have similar sounding names but very different actions. If a patient received the incorrect medication, it could cause serious complications. Facility managers reported the look-alike/sound-alike pair, and VA Medsafe published a warning in the February 2012 edition of *Medication Safety in Seconds*.[2]

[1] A strong string is an intermediate or stronger action with a quantifiable outcome measure and management concurrence.
[2] "Diazepam and Diltiazem Potential Look-Alike (LA)/ Sound Alike (SA) Confusion," *Medication Safety in Seconds,* Vol. 2, No. 2, February 2012, p. 3.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's domiciliary was in compliance with selected MH RRTP requirements.

We inspected two domiciliary and two CLC units, the intensive care unit, and the medical inpatient unit. We also inspected the emergency department and the dental, physical therapy, occupational therapy, spinal cord injury, primary care, and behavioral mental health outpatient clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Spinal Cord Injury EOC
	EOC requirements specific to the Spinal Cord Injury Center and/or outpatient clinic were met.
	Spinal cord injury-specific training was provided to staff working in the Spinal Cord Injury Center and/or spinal cord injury outpatient clinic.
	The facility complied with any additional elements required by local policy.

	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
X	Actions were initiated when deficiencies were identified in the residential environment.
X	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Meeting Minutes. The Joint Commission requires the facility to identify and monitor EOC issues and to take action on identified deficiencies until resolved. We reviewed monthly EOC Committee minutes and determined that environmental issues in the MH RRTP were not identified and tracked to resolution and closure.

MH RRTP Residential Environment. The Joint Commission requires that areas used by patients are clean. VHA requires MH RRTPs to provide safe, well maintained, and appropriately furnished residential environments and to initiate appropriate corrective actions when deficiencies are identified.[3] Both MH RRTP units had damaged or missing floor tiles. On one unit, we also found broken or missing ceramic wall tiles; uneven floor surfaces in a bathroom; damaged toilet partitions; a rusted and unsecured ceiling vent; multiple furniture items that were stained and torn; and dirty restrooms, showers, and congregate bathrooms.

MH RRTP General Safety. VHA requires that all MH RRTP access points have keyless entry and closed circuit television monitoring.[4] The MH RRTP units are large with numerous entry and exit points and connecting passageways to other buildings. The majority of entry points did not have closed circuit television monitoring. Additionally, passageways from adjacent buildings were not controlled by keyless entry and did not have staff present to control entry. Because of the facility's size and layout, staff cannot always detect exit alarms indicating emergency or unauthorized entry.

Recommendations

1. We recommended that processes be strengthened to ensure that environmental deficiencies in the MH RRTP are reported in EOC Committee minutes and tracked to resolution and closure.

2. We recommended that the facility maintain a safe and clean MH RRTP residential environment.

[3] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.
[4] VHA Handbook 1162.02.

3. We recommended that the MH RRTP units have closed circuit television monitoring at all access points and that the facility conduct a risk assessment to determine how overall security measures can be strengthened at entry and exit points to comply with VHA policy.

QM

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

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

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

QM Committee Membership. VHA requires that membership of the senior-level committee (QM Council) responsible for QM/performance improvement activities include the facility Director.[5] We found that QM Council membership did not include the Director.

UM. VHA requires facility PUMAs to collaborate with facility UM and medical staff to provide medical recommendations on UM case referrals that did not meet acute inpatient care criteria.[6] We reviewed 10 cases that did not meet the required criteria and were referred to the PUMA by the UM reviewer. For seven of these cases, we found no evidence that the PUMA responded, collaborated, or made any medical recommendations.

Recommendations

4. We recommended that the Director be added as a member of the QM Council.

5. We recommended that processes be strengthened to ensure that the PUMA responds to, collaborates on, and makes medical recommendations for all cases referred by the UM reviewer.

[5] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[6] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on the acute care unit.

We reviewed relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel, which include convening unit-based and facility expert panels, be completed by September 30, 2011.[7] The facility did not convene unit-based and facility expert panels until February 2012.

Recommendation

6. We recommended that facility nursing leadership develop and implement a nurse staffing methodology.

[7]VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Outpatient Case Management. VHA requires that a specific interdisciplinary treatment plan for each polytrauma outpatient be developed.[8] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. Eight of the EHRs either did not have the required treatment plan, or the treatment plan did not include all required elements.

Recommendation

7. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients and that the plans contain all required elements.

[8] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
X	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Competency Assessment. VHA requires the facility to complete and document training and competency assessments for all employees who perform glucose POCT.[9] The College of American Pathologists requires that after successful initial training and competency assessment, employees must have competency reassessed in 6 months. All employees who perform glucose POCT must then have competency assessed annually. Of the five new employee training and competency records reviewed, two employees did not have documented evidence of competency reassessment at 6 months.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to document specific elements,

[9] VHA Handbook 1106.01 *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008.

including the individual performing the test, provider notification, and provider read back of the critical test result in a designated template. For 9 of the 10 patients who had critical test results, there was no documentation of one or more of the required elements.

Recommendations

8. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed at the required intervals.

9. We recommended that processes be strengthened to ensure that staff complete and document the elements required in response to critical test results and that compliance be monitored.

Review Activities Without Recommendations

COC

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

We reviewed 13 HF patients' EHRs and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

CRC Screening

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

We reviewed the EHRs of 19 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[10] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 16 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients who for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[10] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

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 18–24, for the full text of the Directors' comments.) We consider Recommendation 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[11]		
Type of Organization	Rural medical center	
Complexity Level	3	
VISN	2	
Community Based Outpatient Clinics	Elmira, NY Wellsville, NY	
Veteran Population in Catchment Area	29,024	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	235	
• **CLC/Nursing Home Care Unit**	124	
• **Other**	0	
Medical School Affiliation(s)	none	
• **Number of Residents**	0	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$88.9	$86.3
• **Medical Care Expenditures**	$44.4	$80.8
Total Medical Care Full-Time Employee Equivalents	706	705.2
Workload:		
• **Number of Station Level Unique Patients**	8,872	12,468
• **Inpatient Days of Care:**		
○ **Acute Care**	855	2,575
○ **CLC/Nursing Home Care Unit**	12,935	38,831
Hospital Discharges	270	806
Total Average Daily Census (including all bed types)	308.3	296.6
Cumulative Occupancy Rate (in percent)	78.3	75.2
Outpatient Visits	52,351	161,184

[11] All data provided by facility management.

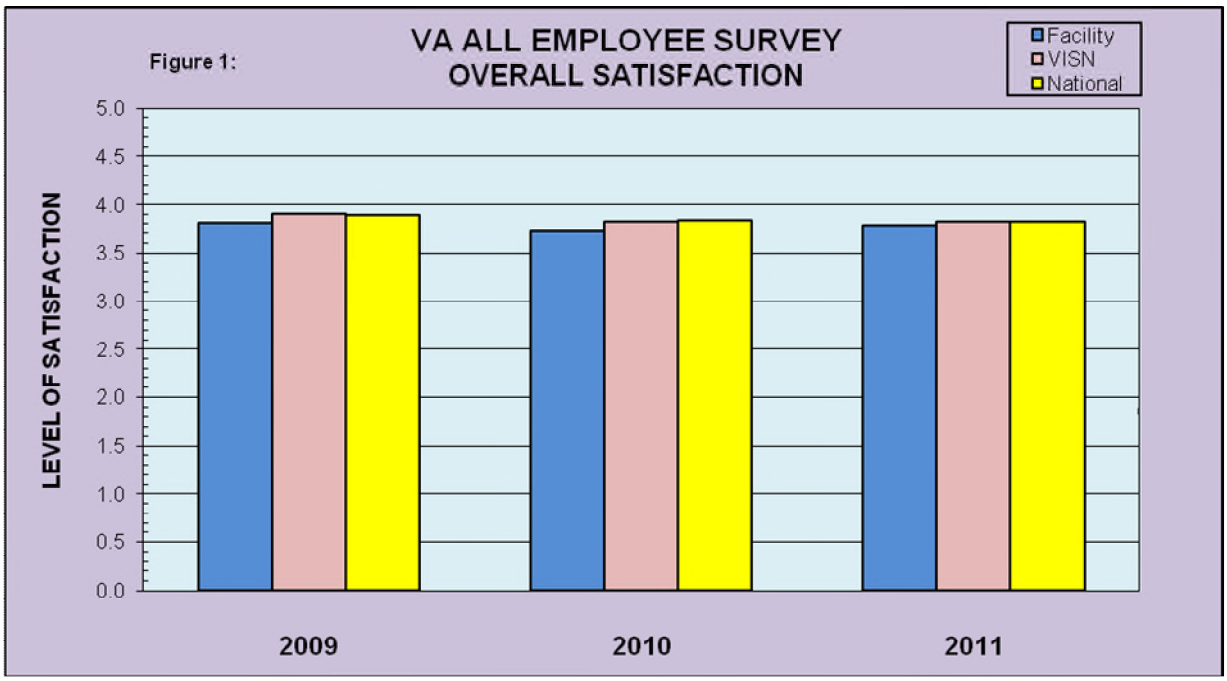
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 2011 and quarter 1 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011		FY 2011			FY 2012
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1
Facility	59.7	66.0	54.4	55.0	52.6	55.5
VISN	66.4	65.4	61.8	58.4	61.3	62.4
VHA	63.9	64.1	55.3	54.2	54.5	55.0

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[12] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[13]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	12.3	11.3	**	26.1	18.9
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 2, 2012

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

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

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

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

VISN 2 concurs with the findings noted therein, and submit for your review and approval our recommendations to resolve the identified findings.

(original signed by:)
David J. West, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 25, 2012

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

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

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

Review of the findings contained in the subject Combined Assessment Program Review conducted during the week of May 7, 2012 has been completed. We concur with the findings noted therein, and submit for your review and approval our recommendations to resolve the identified findings.

(original signed by:)
MICHAEL J. SWARTZ, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that environmental deficiencies in the MH RRTP are reported in EOC Committee minutes and tracked to resolution and closure.

Concur

Target date for completion: July 17, 2012

Environmental deficiencies observed by the OIG reviewer on-site, including broken and/or missing tiles in DRRTP buildings, were corrected during the OIG CAP review.

Medical Center Memorandum 300-003-036 "Housekeeping in the Domiciliary Residential Rehabilitation and Treatment Program (DRRTP) Buildings" was evaluated. The policy was updated to reflect the following change in procedure: Environmental deficiencies identified in the DRRTP that require action by another department will be reported via the electronic work order process.

Pending electronic work orders specific to DRRTP buildings will be reported to the Environment of Care Committee by the Chief Engineer on a monthly basis beginning July 17, 2012. These reports will be tracked in EOC Committee minutes through resolution.

Recommendation 2. We recommended that the facility maintain a safe and clean MH RRTP residential environment.

Concur

Target date for completion: July 17, 2012

Per Medical Center Memorandum 300-003-036, "Housekeeping in the Domiciliary Residential Rehabilitation and Treatment Program (DRRTP) Buildings," daily walk-through inspections of the living areas of DRRTP buildings are conducted by Domiciliary Assistant staff. Every two weeks a joint inspection is conducted by Domiciliary Assistant staff and Environment Management Staff (EMS).

An EMS Inspection Sheet is utilized to conduct the walk-through inspections. All identified deficiencies are documented and monitored through correction.

Housekeeping Aid Closets (HACs) are manned by Incentive Therapy Program (ITP) staff to assure cleaning supplies are readily available to DRRTP residents. Processes

to hold DRRTP residents accountable for their immediate environments include consequences for noncompliance with policy.

Recommendation 3. We recommended that the MH RRTP units have closed circuit television monitoring at all access points and that the facility conduct a risk assessment to determine how overall security measures can be strengthened at entry and exit points to comply with VHA policy.

Concur

Target date for completion: August 31, 2012

A Vulnerable Assessment Survey (VAST) was conducted on the facility on December 2, 2010. This assessment was in addition to the annual facility-wide Physical Security Risk Assessment conducted by the Chief, VA Police and Security. The VAST survey scored VAMC Bath as "Medium High" based on a physical security classification of "Medium Low," a risk classification of "Medium High" and an asset risk value of "High."

A facility-wide security project was planned to mitigate the VAST finding. The security project will address the access control of the external doors in buildings 104, 34, and 24 by installing a Physical Access Control System (PACS), visual monitoring of the doors by CCTV/SSTV cameras, and establish a centralized monitoring center "central dispatch" for the systems. The PACS system will be integrated with the camera system. Once a door is accessed an alarm will sound in the central dispatch and the camera at that location will activate providing the dispatcher with a view of who has accessed the area. The dispatcher will be able to grant access to doors or lock the entire building from the central dispatch location.

As of June 20, 2012, Phase 1 of the security project was completed with Phase 2 (Design Process) due for completion September 30, 2012. The project moves from there to contracting for the next two months. From contracting the project moves to a two month process of procurement of goods by contracted vendor, then the final phase (completion of project) for two months. Projected date of security project is April, 2013.

Measures to mitigate risks to security and safety of DRRTP residents and staff include the following:

With the exception of the major point of entry to building 104, at 9:00pm all points of entry to DRRTP buildings are locked and alarmed. Domiciliary Assistants respond to triggered alarms to ensure the safety and security of the area.

Rounds are conducted by Domiciliary Assistants at least every two hours in all areas to include hallways, dayrooms, group rooms, stairwells and community bathrooms. Rounds through patient rooms occurs twice a shift. A record of rounds is maintained by Domiciliary Assistants and reviewed by supervisory staff daily. At least one staff person is physically present in each building that houses patients.

During times of unavoidable staffing vacancies the intent of rounds is met by situational awareness via the closed circuit monitoring system and by increasing rounds to hourly in the area without the physical presence of Domiciliary Assistants.

All bedroom doors in DRRTP buildings are secured by a lock system with key entry and auto lock capability. Each resident has a key to their bedroom and is instructed to keep their door locked at all times.

Patient activity in all patient areas is monitored 24/7 by DRRTP staff by a closed circuit monitoring system with recording capability triggered by motion is used to provide situational awareness to DRRTP staff in promoting the safety and security of DRRTP patients.

Recommendation 4. We recommended that the Director be added as a member of the QM Council.

Concur

Target date for completion: June 22, 2012

The Organizational Improvement Committee (OIC) was recently identified as the leadership committee that reviews and analyzes quality data, takes appropriate actions and tracks improvements to completion. These processes had been previously accomplished at another Facility Committee that the Medical Center Director was not a member of. This new committee was officially chartered April 24, 2012 and includes the Medical Center Director as a member.

Recommendation 5. We recommended that processes be strengthened to ensure that the PUMA responds to, collaborates on, and makes medical recommendations for all cases referred by the UM reviewer.

Concur

Target date for completion: June 30, 2012

The PUMA and Utilization Management (UM) RN at Bath attend daily Interdisciplinary Treatment Discharge Planning meetings on the acute care unit where admission and continued stay recommendations are discussed. In the event the PUMA is not available to attend this meeting, the UM RN communicates with PUMA by message in Microsoft outlook and maintains record of second level review/recommendations of PUMA on a spreadsheet. Admission and continued stay days not meeting InterQual criteria (with reasons) are reported quarterly to Executive Committee of Medical Staff.

Recommendation 6. We recommended that facility nursing leadership develop and implement a nurse staffing methodology.

Concur

Target date for completion: June 8, 2012

As of June 8, 2012, the Bath VA Medical Center has implemented nurse staffing methodology per VHA Directive 2010-034. Team members were identified at the unit level by tour of duty. Labor representatives for each area were identified. Charters for facility and unit level teams have been developed. Team members were educated. This education was recorded. The link to vaww.va.gov/nursing/staffing.asp has been provided to all team members. Team meetings are occurring with minutes and attendance recorded and maintained in a centralized location. Data is collected for analysis and evaluation of workload and outcomes measures.

Each unit expert panel has conducted a review for appropriateness. Findings will be presented to the facility expert panel who aligns recommendations with budget planning and funding allocation and provides feedback to units.

The facility expert panel requests additional information to support findings as appropriate prior to presentation for finalized approval by the Associate Director for Patient Nursing Services (ADPNS) and Medical Center Director.

Recommendation 7. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients and that the plans contain all required elements.

Concur

Target date for completion: June 30, 2012

The Interdisciplinary Polytrauma Support Clinic Team (PSCT) at Bath implemented Individualized Rehabilitation and Community Reintegration Plans of Care for existing and admitted polytrauma outpatients. This Plan of Care addresses all required elements per VHA Handbook 1172.04, Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan.

Recommendation 8. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed at the required intervals.

Concur

Target date for completion: July 31, 2012

An evaluation of the POCT competence process revealed ambiguity regarding the six month competency. Observation of psychomotor skill and an online assessment of

cognitive skill are required. Improved communication between laboratory personnel and nursing leadership has resulted in improved compliance with initial, six month and annual competencies. Initial and ongoing POCT competencies are tracked and reported through the Laboratory Manager to Nurse Managers. 100% compliance is required.

Recommendation 9. We recommended that processes be strengthened to ensure that staff complete and document the elements required in response to critical test results and that compliance be monitored.

Concur

Target date for completion: October 31, 2012

A process to ensure documentation of required elements in response to critical POCT fingerstick glucose results was initiated May 18, 2012. Once a week, the Lab provides to the Associate Director for Patient Nursing Services (ADPNS) a report listing critical fingerstick glucose test results for the previous seven days. Within this report is the presence (or absence) of a progress note and the presence (or absence) of required components of documentation within the note. Per local policy, use of the Critical Value Nursing Note is required. If this note is not used, the report reflects evidence of other documentation that may contain the required elements of a critical fingerstick glucose result.

Reviews of the Critical Value documentation report will be conducted through four consecutive weeks with greater than 90% compliance, then monthly through three consecutive months with greater than 90% compliance will be conducted by Nurse Managers and the Associate Chief Nurses for GEC and MVAC. Reviews will be reported at Accreditation Committee until recommendation closure by OIG and to Nursing Leadership if required, for follow up.

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