
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 13-00897-242**

# Combined Assessment Program Review of the VA Western New York Healthcare System Buffalo, New York

**July 15, 2013**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Telephone: 1-800-488-8244**
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# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CLC | community living center |
| CPR | cardiopulmonary resuscitation |
| CS | controlled substances |
| EHR | electronic health record |
| EOC | environment of care |
| facility | VA Western New York Healthcare System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HPC | hospice and palliative care |
| NA | not applicable |
| NC | noncompliant |
| OIG | Office of Inspector General |
| PCCT | Palliative Care Consult Team |
| PRC | Peer Review Committee |
| QM | quality management |
| RME | reusable medical equipment |
| SPS | Sterile Processing Service |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of April 29, 2013.

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

- Environment of Care

The facility's reported accomplishments were lean project success in wheelchair management, the offering of Kids' Korner services to veterans, and receiving the Energy Star® Award for the past 5 years.

**Recommendations:** We made recommendations in the following six activities:

*Quality Management:* Consistently complete peer review action items, and report results to the Peer Review Committee. Initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Revise the local observation bed policy to include all required elements, and gather data about observation bed use. Review each resuscitation code episode. Perform a quarterly review of the quality of entries in electronic health records that includes all services. Include all required elements in the quality control policy for scanning, and consistently scan the results of non-VA purchased diagnostic tests into electronic health records. Ensure the blood usage and review process includes the number of units that were outdated or otherwise discarded, the results of proficiency testing, and the results of inspections by government or private (peer) entities.

*Medication Management – Controlled Substances Inspections:* Consistently reconcile 1 day's dispensing from the pharmacy to each automated unit. Validate hard copy orders for five randomly selected dispensing activities in all non-pharmacy controlled substances areas. Consistently verify audit trails for the destruction of 10 randomly selected drugs at the Batavia pharmacy. Ensure controlled substances inspectors receive annual updates and/or refresher training.

*Coordination of Care – Hospice and Palliative Care:* Ensure non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training. Offer bereavement services to patients and families.

*Pressure Ulcer Prevention and Management:* Ensure staff are consistent in pressure ulcer documentation. Consistently perform and document daily skin inspections and/or daily risk scales. Provide pressure ulcer education to patients at risk for or with pressure ulcers and/or their caregivers. Ensure designated employees receive training on how to accurately document pressure ulcer findings.

*Nurse Staffing:* Monitor the staffing methodology that was implemented in December 2012.

*Construction Safety:* Ensure designated employees receive ongoing construction safety training.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–26, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

# Objectives and Scope

## Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may 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, FY 2012, and FY 2013 through April 26, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Western New York Healthcare System, Buffalo, New York*, Report No. 08-02565-204, August 31, 2009). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 107 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 225 responded. We shared summarized 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

## Lean Project Success in Wheelchair Management

The management of facility wheelchairs was selected as a lean project to increase wheelchair availability, ensure appropriate distribution, and document safety inspections for and sanitation and maintenance of wheelchairs. The facility established an Incentive Work Therapy Infection Prevention Team responsible for collecting, tracking, and sanitizing wheelchairs. Team members station themselves at outpatient entrances, in parking lots, and on units to tag and designate wheelchairs to meet the needs of the units and clinics. The efforts have reduced the amount of time patients spend waiting for transportation to appointments, have improved the ability to track sanitation and maintenance of wheelchairs, and have provided meaningful work therapy assignments.

## Kids' Korner Pilot

In October 2011, the facility's Buffalo campus began offering childcare for children ages 6 weeks to 12 years who accompany veterans to medical appointments. Kids' Korner is available weekdays and is free of charge. The service is in response to a national VA study that showed that more than 10 percent of veterans had to cancel or reschedule appointments due to lack of childcare. Kids' Korner is part of a 2-year VHA pilot in which 12 facilities submitted proposals. The facility was one of the three selected to participate and was the first to offer the service.

## Energy Star® Award Winner

The facility has been a recipient of the Energy Star® Award from the U.S. Environmental Protection Agency for the past 5 years. The award recognizes facilities that use 35 percent less energy and generate 35 percent less greenhouse gas emissions than similar hospitals (general medical and surgical) across the nation. In 2012, the facility was 1 of 54 facilities (7 VHA and 47 non-VHA) in the country to receive the award.

# Results and Recommendations

## 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.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members. | |
| | There was evidence that Inpatient Evaluation Center data was discussed by senior managers. | |
| X | Corrective actions from the protected peer review process were reported to the PRC. | Six months of PRC meeting minutes reviewed:<br>• Of three actions expected to be completed, two were not reported to the PRC. |
| X | FPPEs for newly hired licensed independent practitioners complied with selected requirements. | Twenty-five profiles reviewed:<br>• None of the FPPEs were initiated. This was a repeat finding from the previous CAP review. |
| X | Local policy for the use of observation beds complied with selected requirements. | Facility policy reviewed:<br>• The facility's policy did not include assessment expectations or that each observation patient must have a focused goal for the period of observation. |
| X | Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization. | • The facility did not gather observation bed use data. |
| | Staff performed continuing stay reviews on at least 75 percent of patients in acute beds. | |
| | Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery. | |
| X | The CPR review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted. | Six months of CPR meeting minutes reviewed:<br>• There was no evidence that the committee reviewed each code episode. |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | There was an EHR quality review committee, and the review process complied with selected requirements. | Six months of Medical Record Committee meeting minutes reviewed:<br>• There was no evidence that the quality of entries in the EHR was reviewed quarterly.<br>• Not all services were included in review of EHR quality. |
| | The EHR copy and paste function was monitored. | |
| X | Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs. | • The quality control policy for scanning did not include image quality, linking of scanned documents to the correct record, and indexing the documents.<br><br>Sixteen EHRs of patients who had non-VA purchased diagnostic tests reviewed:<br>• Three test results were not scanned into the EHRs. |
| X | Use and review of blood/transfusions complied with selected requirements. | Three quarters of Transfusion Committee meeting minutes reviewed:<br>• The review process did not include the number of units that were outdated or otherwise discarded, the results of proficiency testing, and the results of inspections by government or private (peer) entities. |
| | CLC minimum data set forms were transmitted to the data center with the required frequency. | |
| | Overall, if significant issues were identified, actions were taken and evaluated for effectiveness. | |
| | There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated. | |
| | 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 VHA or local policy. | |

## Recommendations

**1.** We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the PRC.

**2.** We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are initiated.

**3.** We recommended that the local observation bed policy be revised to include all required elements and that processes be strengthened to ensure that data about observation bed use is gathered.

**4.** We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode.

**5.** We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed quarterly and that the review includes all services.

**6.** We recommended that the quality control policy for scanning includes image quality, linking of scanned documents to the correct record, and indexing the documents and that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

**7.** We recommended that processes be strengthened to ensure that the blood usage and review process includes the number of units that were outdated or otherwise discarded, the results of proficiency testing, and the results of inspections by government or private (peer) entities.

## EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in the hemodialysis and SPS areas were met.[2]

At the Buffalo campus, we inspected two medical/surgical units, the behavioral health and intensive care inpatient units, and one CLC. We also inspected SPS; the emergency and physical therapy departments; and the primary care, oncology, and dialysis clinics. At the Batavia campus, we inspected the primary care clinic and one CLC. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training and competency files (10 hemodialysis, 10 operating room, and 9 SPS). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed for General EOC | Findings |
|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure. | |
| | An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas. | |
| | Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data. | |
| | 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 VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for Hemodialysis** | |
| | The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients. | |
| | Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected. | |

| NC | Areas Reviewed for Hemodialysis (continued) | Findings |
|---|---|---|
| | Employees received training on bloodborne pathogens. | |
| | Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented. | |
| | Selected EOC/infection prevention/safety requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for SPS/RME** | |
| | The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME. | |
| | The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee. | |
| | The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it. | |
| | Employees received required RME training and competency assessment. | |
| | Operating room employees who performed immediate use (flash) sterilization received training and competency assessment. | |
| | RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required. | |
| | Selected infection prevention/environmental safety requirements were met. | |
| | Selected requirements for SPS decontamination and sterile storage areas were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |

## Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | Facility policy was consistent with VHA requirements. | |
| | VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected. | |
| X | Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed. | Automated dispensing machine inspection instructions reviewed:<br>• In two CS areas, inspectors did not consistently reconcile 1 day's dispensing from the pharmacy to each automated dispensing machine. |
| | Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director. | |
| | CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest. | |
| X | CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest. | Appointments, certifications, and training records reviewed:<br>• Six CS inspectors did not receive annual updates and/or refresher training. |
| X | Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements. | Documentation of 10 CS areas inspected during the past 6 months reviewed:<br>• In four CS areas, inspectors did not validate hard copy orders for five randomly selected dispensing activities. |
| X | Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements. | Documentation of pharmacy CS inspections during the past 6 months reviewed:<br>• Inspectors did not consistently verify audit trails for destruction of 10 randomly selected drugs at the Batavia pharmacy. |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Recommendations

**8.** We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled; that hard copy orders for 5 randomly selected dispensing activities are validated in all non-pharmacy CS areas; and that at the Batavia pharmacy, audit trails for destruction of 10 randomly selected drugs are consistently verified.

**9.** We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

## Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 21 employee training records (6 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | A PCCT was in place and had the dedicated staff required. | |
| | The PCCT actively sought patients appropriate for HPC. | |
| | The PCCT offered end-of-life training. | |
| X | HPC staff and selected non-HPC staff had end-of-life training. | • There was no evidence that 10 non-HPC staff had end-of-life training. |
| | The facility had a VA liaison with community hospice programs. | |
| | The PCCT promoted patient choice of location for hospice care. | |
| X | The CLC-based hospice program offered bereavement services. | • We did not find evidence that the CLC offered bereavement services to patients and families. |
| | The HPC consult contained the word "palliative" or "hospice" in the title. | |
| | HPC consults were submitted through the Computerized Patient Record System. | |
| | The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon. | |
| | Consult responses were attached to HPC consult requests. | |
| | The facility submitted the required electronic data for HPC through the VHA Support Service Center. | |
| | An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe. | |
| | HPC inpatients were assessed for pain with the frequency required by local policy. | |
| | HPC inpatients' pain was managed according to the interventions included in the care plan. | |
| | HPC inpatients were screened for an advanced directive upon admission and according to local policy. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| | The facility complied with any additional elements required by VHA or local policy. | |

## Recommendations

**10.** We recommended that processes be strengthened to ensure that non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

**11.** We recommended that processes be strengthened to ensure that the CLC-based hospice program offers bereavement services to patients and families.

## Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 23 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care. | |
| | The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist. | |
| | Pressure ulcer data was analyzed and reported to facility executive leadership. | |
| | Complete skin assessments were performed within 24 hours of acute care admissions. | |
| | Skin inspections and risk scales were performed upon transfer, change in condition, and discharge. | |
| X | Staff were generally consistent in documenting location, stage, risk scale score, and date acquired. | • In 12 of the 23 EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired. |
| X | Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers. | • Thirteen of the 20 applicable EHRs did not contain consistent documentation that staff performed daily skin inspections and daily risk scales. |
| X | Required activities were performed for patients determined to not be at risk for pressure ulcers. | • None of the three applicable EHRs contained consistent documentation that staff performed daily skin inspections. |
| | For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided. | |
| | If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers. | Facility pressure ulcer patient and caregiver education requirements reviewed:<br>• For four of the applicable patients, EHRs did not contain evidence that education was provided. |
| X | The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings. | Facility pressure ulcer staff education requirements reviewed:<br>• Five employee training records did not contain evidence of training on how to accurately document findings. |
| | The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms. | |
| X | The facility complied with any additional elements required by VHA or local policy. | VHA policy reviewed:<br>• Eighteen of the 23 EHRs contained inconsistent documentation of wound characteristics or whether the wound had improved or deteriorated during the admission and/or at the time of discharge. |

## Recommendations

**12.** We recommended that processes be strengthened to ensure that staff are consistent in pressure ulcer documentation of location, stage, size, characteristics, risk scale score, and date acquired and whether the wound has improved or deteriorated during the admission or at the time of discharge.

**13.** We recommended that processes be strengthened to ensure that staff consistently perform and document daily skin inspections and/or daily risk scales.

**14.** We recommended that processes be strengthened to ensure that pressure ulcer education is provided to patients at risk for or with pressure ulcers and/or their caregivers.

**15.** We recommended that processes be strengthened to ensure that designated employees receive training on how to accurately document pressure ulcer findings and that compliance be monitored.

## 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 three inpatient units (acute medical/surgical, long-term care, and mental health).[6]

We reviewed relevant documents and 30 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute post-surgical unit 5C, mental health unit 10D, and CLC unit Ward B at the Batavia campus for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| X | The facility completed the required steps to develop a nurse staffing methodology by the deadline. | • Required steps to develop a staffing methodology were not completed until December 2012. |
| NA | The unit-based expert panels followed the required processes and included all required members. | |
| NA | The facility expert panel followed the required processes and included all required members. | |
| NA | Members of the expert panels completed the required training. | |
| NA | The actual nursing hours per patient day met or exceeded the target nursing hours per patient day. | |
| NA | The facility complied with any additional elements required by VHA or local policy. | |

### Recommendation

**16.** We recommended that nurse managers monitor the staffing methodology that was implemented in December 2012.

## Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected the oncology clinic renovation project. Additionally, we reviewed relevant documents and 17 training records (3 contractor records and 14 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members. | |
| | Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation. | |
| | There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results. | |
| | There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented. | |
| | Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements. | |
| | Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions. | |
| | Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion. | |
| X | Contractors and designated employees received required training. | Employee and contractor training records reviewed:<br>• Six employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years. |
| | Dust control requirements were met. | |
| | Fire and life safety requirements were met. | |
| | Hazardous chemicals requirements were met. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| | Storage and security requirements were met. | |
| | The facility complied with any additional elements required by VHA or local policy or other regulatory standards. | |

## Recommendation

**17.** We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

| Facility Profile (Buffalo/528) FY 2013 through March 2013[a] | |
|---|---|
| **Type of Organization** | Tertiary |
| **Complexity Level** | 1c |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions (Parent Facility 2012)** | $299 |
| **Number of:** | |
| • **Unique Patients** | 47,572 |
| • **Outpatient Visits** | 282,451 |
| • **Unique Employees**[b] | 1,543 |
| **Type and Number of Operating Beds: (through February 2013)** | |
| • **Hospital** | 145 |
| • **CLC** | 120 |
| • **Mental Health** | 60 |
| **Average Daily Census: (through February 2013)** | |
| • **Hospital** | 103 |
| • **CLC** | 102 |
| • **Mental Health** | 38 |
| **Number of Community Based Outpatient Clinics** | 6 |
| **Location(s)/Station Number(s)** | Jamestown/582GB<br>Dunkirk/528GC<br>Niagara Falls/528GD<br>Lockport/528GK<br>Lackawanna/528GQ<br>Olean/528GR |
| **VISN Number** | 2 |

[a] All data is for FY 2013 through March 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

# VHA Patient Satisfaction Survey

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

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2012 | | FY 2012 | | | |
| | Inpatient Score Quarters 1–2 | Inpatient Score Quarters 3–4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 |
| Facility | 57.5 | 65.9 | 64.4 | 64.5 | 56.5 | 64.6 |
| VISN | 64.0 | 67.2 | 62.4 | 62.0 | 60.5 | 63.5 |
| VHA | 63.9 | 65.0 | 55.0 | 54.7 | 54.3 | 55.0 |

# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] 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, 2008, and June 30, 2011.[d]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Heart Failure | Pneumonia | Heart Attack | Heart Failure | Pneumonia |
| Facility | 15.0 | 12.1 | 13.7 | 19.5 | 25.7 | 21.2 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[c] 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. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] 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.

**Appendix C**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 24, 2013

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

**Subject:** **CAP Review of the VA Western New York Healthcare System, Buffalo, NY**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed the VA OIG Combined Assessment Program (CAP) review for VA Western New York Healthcare System and concur with the recommendations.

2. VA Western New York Healthcare System has established corrective action plans with designated dates of completion as detailed in the attached report. If any additional information or assistance is needed, please contact Kathryn Varkonda, RN, MSN at 716-862-6380.

*(original signed by Darlene Delancey for:)*
David J. West, FACHE
Network Director

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 24, 2013

**From:** Director, VA Western New York Healthcare System (528/00)

**Subject:** **CAP Review of the VA Western New York Healthcare System, Buffalo, NY**

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

I have reviewed the VA OIG Combined Assessment Program (CAP) review for VA Western NewYork Healthcare System and concur with the recommendations.

VA Western New York Healthcare System has established corrective action plans with designated dates of completion as detailed in the attached report. If additional information or assistance is needed, please contact Kathryn Varkonda, RN, MSN at (716) 862-6380.

*(original signed by:)*
BRIAN G. STILLER
Medical Center Director

# 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 actions from peer reviews are consistently completed and reported to the PRC.

Concur

Target date for completion: May 20, 2013

Facility response: The Chief of Staff has implemented a tracking tool for all recommendations coming from PRC. These actions will be tracked to completion on the PRC minutes and displayed.

**Recommendation 2.** We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are initiated.

Concur

Target date for completion: June 20, 2013

Facility response:

1. Facility FPPE policy presented on June 20, 2013 at Credentialing and Privileging Committee, approved by full committee.
2. FPPE initiation documents will be brought to the Credentialing and Privileging Coordinator for presentation to the Credentialing and Privileging Committee as part of the approval process.
3. FPPE initiation documents will be made available to the Medical Center Director before final approval will be given.

**Recommendation 3.** We recommended that the local observation bed policy be revised to include all required elements and that processes be strengthened to ensure that data about observation bed use is gathered.

Concur

Target date for completion: June 21, 2013

Facility response:

1. The Observation Bed Policy (Center Memorandum 11-064) had been amended to include all required elements and assessment expectations as found in VHA Directive 2012-011.

2. Utilization Management will ensure that data regarding appropriateness of observation bed use is gathered and conversions to acute admissions are less than 30 percent.
3. Observation criteria to monitor proper utilization in compliance with VHA Directive 2012-011.

**Recommendation 4.** We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode.

Concur

Target date for completion: April, 16, 2013

Facility response: Tracking information has been added to the CPR Committee minutes.

**Recommendation 5.** We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed quarterly and that the review includes all services.

Concur

Target date for completion: June 30, 2013

Facility response: A medical records tracking system was developed to provide EHR review of all services offered. This tool will include specific review criteria for monitoring data and will be reviewed by Medical Records Committee.

**Recommendation 6.** We recommended that the quality control policy for scanning includes image quality, linking of scanned documents to the correct record, and indexing the documents and that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: June 30, 2013

Facility response:

1. The Center Memorandum outlining the process for scanning of documents will be reviewed to include the image quality, linking of scanned documents to the correct record and indexing the documents. Once the documents have been scanned by the service or CBOC, they will then fall under the Quality Assurance Center Memorandum to ensure image quality, linking of scanned documents to the correct record, and indexing the documents to provide access by the providers.

2. The document scanning process will be reviewed to ensure that scanned documents related to Non-VA purchased diagnostic tests maintain the same level quality as internally scanned documents. This will be monitored through the Medical Records Committee.

**Recommendation 7.** We recommended that processes be strengthened to ensure that the blood usage and review process includes the number of units that were outdated or otherwise discarded, the results of proficiency testing, and the results of inspections by government or private (peer) entities.

Concur

Target date for completion: June 12, 2013

Facility response: The following information will be reported and monitored by the Transfusion Committee on a monthly basis:

1. The number of units that were outdated or otherwise discarded,
2. The results of all (not just sub-optimal) Blood Bank proficiency tests, and
3. The results of inspections by government or private (peer) entities.

**Recommendation 8.** We recommended that processes be strengthened to ensure that 1 day's dispensing from the pharmacy to each automated unit is consistently reconciled; that hard copy orders for 5 randomly selected dispensing activities are validated in all non-pharmacy CS areas; and that at the Batavia pharmacy, audit trails for destruction of 10 randomly selected drugs are consistently verified.

Concur

Target date for completion: August 1, 2013

Facility response:

1. During the monthly CS inspection, a dispensing review process will be included on the inspection sheet to ensure that 1 day's dispensing from the pharmacy of each units automated dispensing unit is reconciled.
2. During the monthly CS inspection, five randomly selected dispensing activities will be included on the narcotic inspection sheets to assure that required random dispensing activities are validated in all non-pharmacy CS areas.
3. During the monthly CS inspection, audit trails for the destruction of 10 randomly selected drugs at the Batavia pharmacy will be included on the narcotic inspection sheet to verify that destruction of CS is consistent.

**Recommendation 9.** We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and/or refresher training.

Concur

Target date for completion: June 28, 2013

Facility response: All CS Inspector's will receive annual training using the Controlled Substance Inspection Certification Program in TMS. The TMS system will be used to track compliance. The process for annual updates/refresher training for CS Inspectors will be completed by June 28, 2013.

**Recommendation 10.** We recommended that processes be strengthened to ensure that non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: July 31, 2013

Facility response: All clinical staff providing direct care to end of life patients will be educated using the video "VA Palliative Care: Leading the Way" in TMS. TMS system will be used to track compliance.

**Recommendation 11.** We recommended that processes be strengthened to ensure that the CLC-based hospice program offers bereavement services to patients and families.

Concur

Target date for completion: June 1, 2013

Facility response: Chaplain Services will provide a bereavement support visit for all CLC residents with Advanced Illness/Palliative Care Consult Team consults. Chaplain Services will provide post death phone calls to family/documented NOK (next of kin) for all post patient deaths on a CLC. The medical records will be monitored to ensure that bereavement support is offered to all families in a support group setting or individually.

**Recommendation 12.** We recommended that processes be strengthened to ensure that staff are consistent in pressure ulcer documentation of location, stage, size, characteristics, risk scale score, and date acquired and whether the wound has improved or deteriorated during the admission or at the time of discharge.

Concur

Target date for completion: July 31, 2013

Facility response:

1. All RNs will be educated on the pressure ulcer documentation to include; location, stage, size, characteristics, risk scale score, and date acquired and whether the wound has improved or deteriorated from the date of admission to the date of discharge.
2. The Wound Care Specialists will monitor to ensure that documentation is consistent and comprehensive.

**Recommendation 13.** We recommended that processes be strengthened to ensure that staff consistently perform and document daily skin inspections and/or daily risk scales.

Concur

Target date for completion: July 31, 2013

Facility response: Unit Nurse Managers will monitor that staff consistently perform and document daily skin inspections and/or daily risk scales.

**Recommendation 14.** We recommended that processes be strengthened to ensure that pressure ulcer education is provided to patients at risk for or with pressure ulcers and/or their caregivers.

Concur

Target date for completion: July 31, 2013

Facility response: The Clinical Nurse Educators and the Veterans Health Education Coordinator will work collaboratively to develop and implement an education program for staff RNs to use in providing education to patients at risk for or with pressure ulcers and/or their caregivers. Patient/caregiver education will be monitored monthly by Unit Nurse Manager to ensure that patient health education is being provided and documented.

**Recommendation 15.** We recommended that processes be strengthened to ensure that designated employees receive training on how to accurately document pressure ulcer findings and that compliance be monitored.

Concur

Target date for completion: July 31, 2013

Facility response:

1. The Wound Care Specialists will provide education to RNs on the pressure ulcer documentation relative to wound description, measurements, risk scores and dates on which pressure ulcers were acquired.

2. All pressure ulcer documentation will be monitored monthly by Unit Nurse Managers to include acquired date, wound description, measurements, risk scores, and documentation accuracy and completeness.

**Recommendation 16.** We recommended that nurse managers monitor the staffing methodology that was implemented in December 2012.

Concur

Target date for completion: July 15, 2013 with first quarterly meeting

Facility response: The staffing methodology plan for improvement process is to achieve the following:

1. The Staffing Methodology Coordinator will be a voting member of the facility expert panel (FEP).
2. The FEP will meet on a quarterly basis to review all unit-based expert panel (UEP) recommendations and actual variances to the panel recommendations.
3. All members of the UEP and FEP were educated using the TMS Module: Staffing Methodology for VHA Nursing Personnel: Overview." The TMS system will be used to track this training.
4. On a monthly basis, UEPs will review staffing to identify variances. These variances will be reported quarterly to the FEP to determine if unit level staffing revisions are required.

**Recommendation 17.** We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: May 23, 2013

Facility response: All members of the Construction Safety Committee will be educated using "VHA Construction Safety Training" in TMS. The TMS system will be used to track biennially compliance.

# OIG Contact and Staff Acknowledgments

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This report is available at www.va.gov/oig.

# Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, the International Association of Healthcare Central Service Material Management, and the Association for Professionals in Infection Control and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.