Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03620-102

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

March 26, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Syracuse VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VASQIP	VA Surgical Quality Improvement Program
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 January 27, 2014.

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

- Medication Management
- Coordination of Care
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishments were a revamped Systems Redesign program, the Green Award, and the Computed Tomography Optimization Project.

Recommendations: We made recommendations in the following four activities:

Quality Management: Perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure the Surgical Work Group meets monthly, includes the Chief of Staff and VA Surgical Quality Improvement Program nurse as members, and documents its review of National Surgical Office reports.

Environment of Care: Ensure all occasional locked mental health unit workers receive training on proper use of the Mental Health Environment of Care Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units.

Nurse Staffing: Ensure all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Perform and document patient skin inspections and risk scale scores daily, upon transfer, and at discharge. Consistently document pressure ulcer stages, and revise treatment plans if risk levels change. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–24, 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met 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
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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 2012, FY 2013, and FY 2014 through January 24, 2014, 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 Syracuse VA Medical Center, Syracuse, New York, Report No. 08-02564-163, July 13, 2009).

During this review, we presented crime awareness briefings for 74 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 126 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

Systems Redesign

The facility rolled out InnoVAtion 2013 with the aim of re-branding and re-invigorating the facility's Systems Redesign program. As part of InnoVAtion 2013, a multidisciplinary team provided an infrastructure of support for improvement facility wide. The team established initiatives to exceed veteran expectations, excel at process improvement, and maximize outcomes. As a result, the facility now leads VISN 2 with the highest patient satisfaction scores.

In order to further excel at process improvement, the program trained more than 200 front line staff members in Lean management and the skills necessary to facilitate an improvement team. The result was an inaugural improvement forum at which 33 improvement project teams were on hand to present their projects to more than 400 employees and veterans.

Federal Green Challenge

The facility committed to meet a 5 percent reduction in energy and water consumption. While facility size increased by 22 percent, energy and water reduction projects resulted in a 12 percent decrease in electricity consumption and a 7 percent decrease in water use. For its efforts, the facility received the 2013 Federal Green Challenge Award for Environmental Protection Agency Region 2.

CT Optimization Project

The CT Optimization Committee, in conjunction with the CT Optimization Project, reviewed all of the CT protocols to determine whether it was possible to decrease the radiation exposure to veterans without degrading the diagnostic quality of their CT scans. After a detailed review of the protocols, the committee was able to decrease radiation exposure to veterans by 10 to 50 percent for many common CT scans performed at the facility.

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 met 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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For all 12 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted: • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group met just 3 times over the past 6 months. Three months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff was not a member. • The VASQIP nurse was not a member. • There was no evidence the group reviewed National Surgical Office reports.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

2. We recommended that the Surgical Work Group meet monthly, include the Chief of Staff and VASQIP nurse as members, and document its review of National Surgical Office reports.

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 radiology and acute MH were met.[2]

We inspected the medical/surgical intensive care, acute MH, spinal cord injury, and CLC units and two medical surgical units. We also inspected the radiology and emergency departments and the primary care clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
X	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	• Two of the occasional locked MH unit workers had not completed training on proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units.
	The locked MH unit was in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	

NM	Areas Reviewed for Acute MH (continued)	Findings
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

3. We recommended that processes be strengthened to ensure that all occasional locked MH unit workers receive training on the proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 31 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. 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.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 24 training files, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• Three of the nine members of the unit-based expert panels had not completed the required training. • Six of the 15 members of the facility expert panel had not completed the required training.
NA	The 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 VHA or local policy.	

Recommendation

4. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 25 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 5 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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	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.	
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• Four of the 16 applicable EHRs did not contain documentation that skin inspections and risk scales were performed upon discharge. • Three of the eight applicable EHRs did not contain documentation that skin inspections and risk scales were performed upon transfer to a new unit.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 4 of the 24 applicable EHRs, staff did not consistently document pressure ulcer stages.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Eight of the 22 applicable EHRs did not contain consistent documentation that staff performed daily skin inspections and daily risk scales. • Two of the eight applicable EHRs did not contain consistent documentation that staff revised the prevention plan if the risk level changed.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	

NM	Areas Reviewed (continued)	Findings
	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.	
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: • For 7 of the applicable 16 patients at risk for and with a pressure ulcer, EHRs did not contain evidence that education was provided.
	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.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that processes be strengthened to ensure that acute care staff perform and document patient skin inspections and risk scales daily, upon transfer, and at discharge and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer stages and revise treatment plans when risk levels change and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 16 EHRs of residents (10 residents receiving restorative nursing services and 6 residents not receiving restorative nursing services but candidates for services). We also observed two meal periods, reviewed two employee training/competency records and other relevant documents, and conversed with key employees. 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.

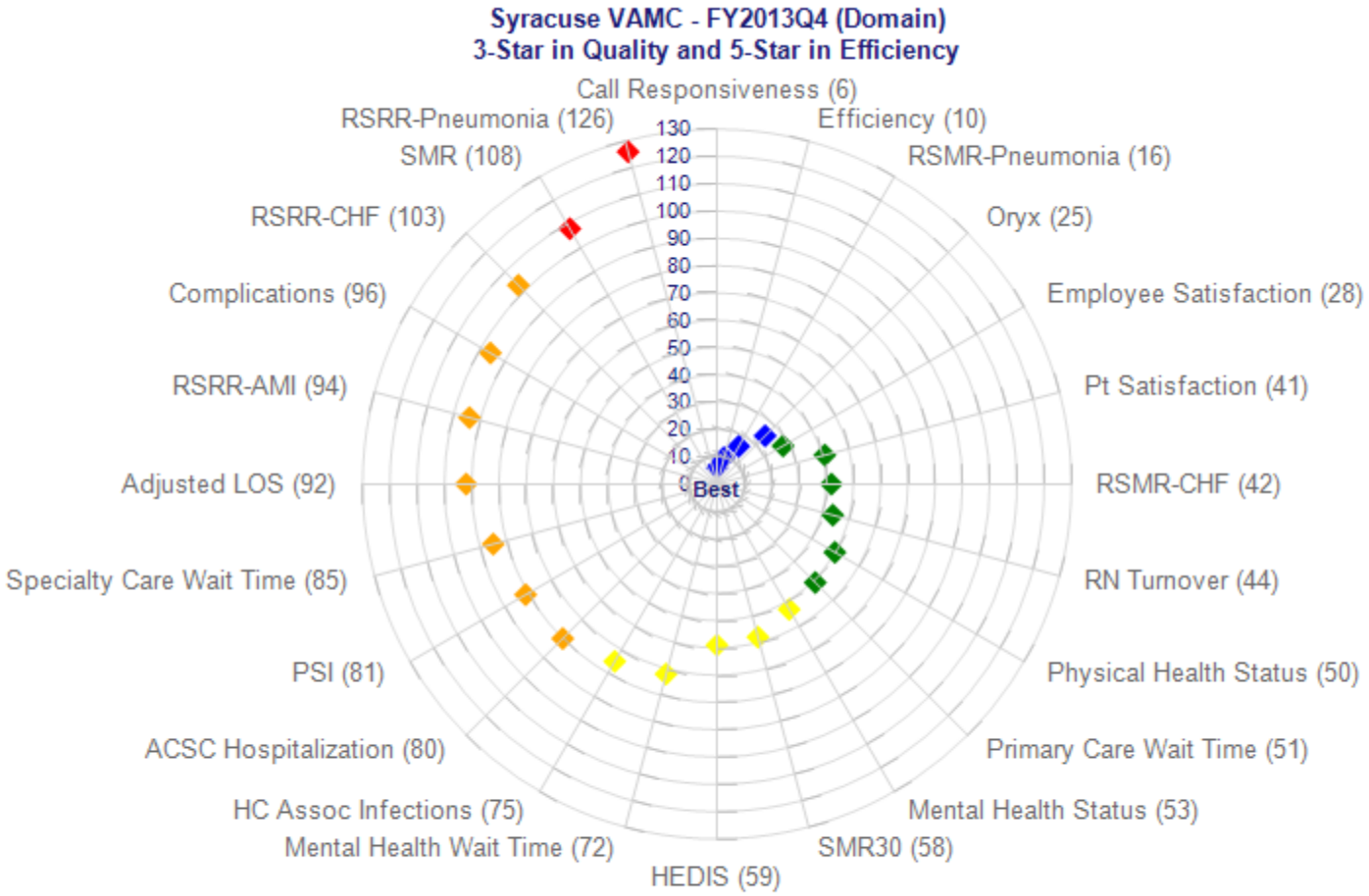
NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
NA	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Syracuse/528A7) FY 2014 through February 2014[a]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$220.6
Number of:	
• **Unique Patients**	37,731
• **Outpatient Visits**	184,573
• **Unique Employees**[b]	1,445
Type and Number of Operating Beds (December 2013):	
• **Hospital**	116
• **CLC**	48
• **MH**	16
Average Daily Census (January 2014):	
• **Hospital**	86
• **CLC**	43
• **MH**	13
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Auburn/528G5 Tompkins/528G9 Massena/528GL Rome/528GM Binghamton/528GN Watertown/528GO Oswego/528GP
VISN Number	2

[a] All data is for FY 2014 through February 2014 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

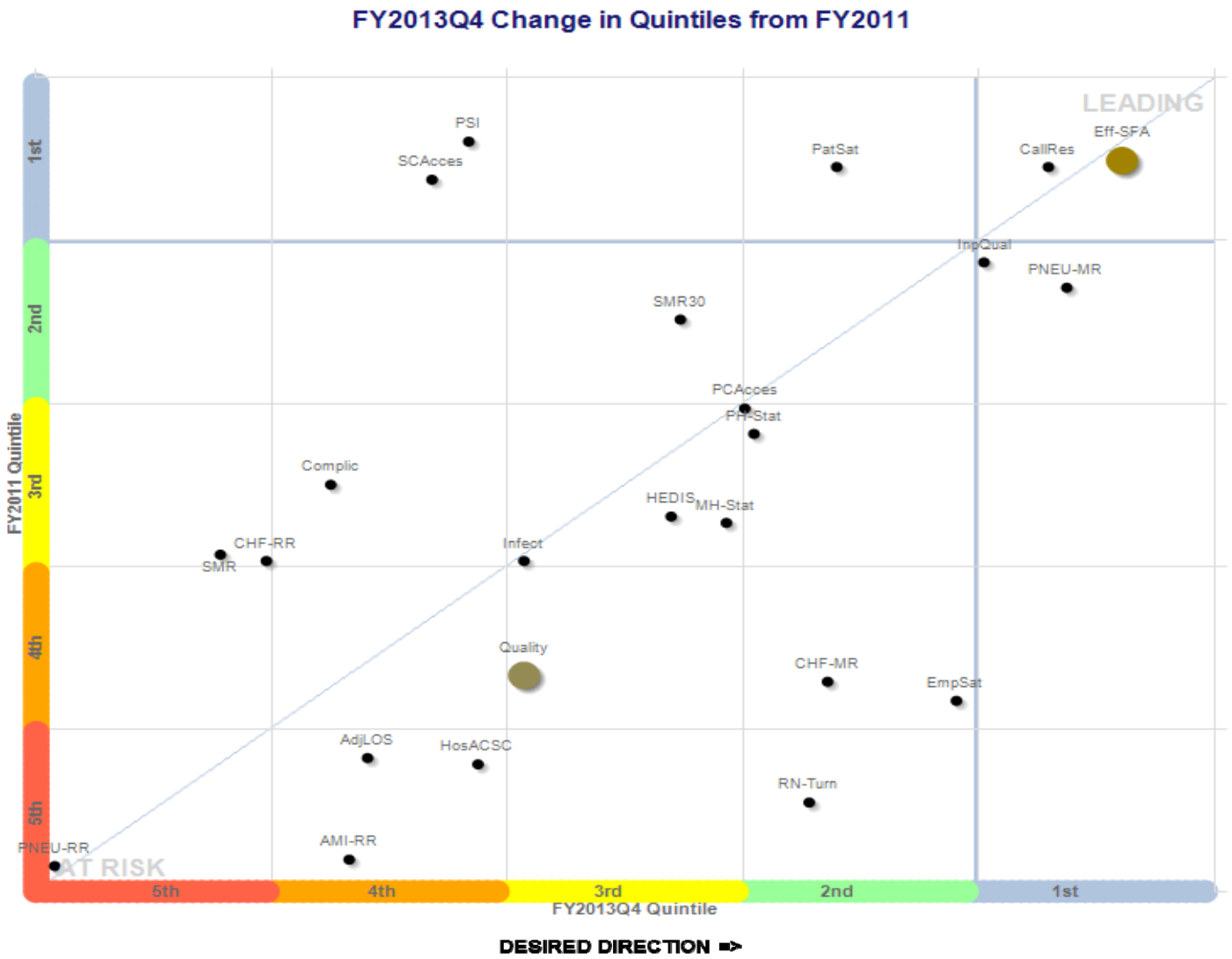
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 10, 2014

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

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

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

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

1. I concur with the findings and recommendations of the Office of Inspector General Combined Assessment Review and have attached the facility action plan to resolve the identified recommendations.

2. If you have any questions or need additional information, please feel free to contact Eric Yeager, Quality Manager at 315-425-4395.

(original signed by:)
Joanne M. Krumberger, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 1, 2014

From: Director, Syracuse VA Medical Center (528A7/00)

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

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

1. I concur with the findings and recommendations of the office of Inspector General Combined Assessment Review and have attached the facility action plan to resolve the identified recommendations. We believe these changes will further enhance key systems and processes at our medical center.

2. If you have any questions or need additional information, please feel free to contact Eric Yeager, Quality Manager at 315-425-4395.

(original signed by:)
James Cody, FACHE
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 continuing stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: May 1, 2014

Facility response: Processes will be strengthened to ensure continued stay reviews will be performed on at least 75 percent of patients in acute beds.

Recommendation 2. We recommended that the Surgical Work Group meet monthly, include the Chief of Staff and VASQIP nurse as members, and document its review of National Surgical Office reports.

Concur

Target date for completion: February 1, 2014

Facility response: As of February 1, 2014, the Surgical Work Group is meeting monthly with both the Chief of Staff and VASQIP Nurse as active participating members. The National Surgical Office report reviews and discussion is now routinely documented in the minutes.

Recommendation 3. We recommended that processes be strengthened to ensure that all occasional locked MH unit workers receive training on the proper use of the MH EOC Checklist and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: January 28, 2014

Facility response: Annual mental health unit training on the mental health environment of care checklist and patient safety study for the two occasional locked mental unit workers was completed on January 28, 2014. Training compliance for all mental health unit workers will be monitored through TMS annually to ensure compliance.

Recommendation 4. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: April 1, 2014

Facility response: All staff assigned to the unit-based and facility-based expert panel for staffing methodology will complete required training per VHA Directive by April 1, 2014. Completion of this training will be tracked and verified by the Nurse Executive prior to the FY15 re-evaluation of staffing methodology.

Recommendation 5. We recommended that processes be strengthened to ensure that acute care staff perform and document patient skin inspections and risk scales daily, upon transfer, and at discharge and that compliance be monitored.

Concur

Target date for completion: May 1, 2014

Facility response: Processes have been strengthened to evaluate and ensure that acute care staff appropriately document patient skin inspections and risk scales upon transfer or discharge. Nursing staff educational programs have been revised to better equip staff to understand the importance of consistently performing accurate skin inspections and risk scale and documenting daily, upon transfer and at discharge. The unit nurse managers will monitor the electronic health record (EHR) weekly to ensure compliance and develop correction plans on the unit level. The Skin Care Wound Assessment Team (SWAT) members will serve as unit resources towards this objective. Auditing results will be reported to the Medical Staff Executive Committee quarterly.

Recommendation 6. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer stages and revise treatment plans when risk levels change and that compliance be monitored.

Concur

Target date for completion: May 1, 2014

Facility response: Processes have been strengthened to ensure that acute care staff accurately document pressure ulcers, including stage and location, and to revise treatment plans when a patient risk level or change in condition occur. Nursing staff educational programs have been revised to better equip staff to perform and document accurate skin inspections, assignment of pressure ulcer stages, and to develop appropriate treatment plans to individual patient needs or condition changes. The individual unit nurse managers will monitor EHR weekly to ensure compliance and develop correction plans on the unit level. The SWAT committee members will serve as

unit resources towards this objective. Auditing results will be reported to the Medical Staff Executive Committee quarterly to ensure compliance is monitored.

Recommendation 7. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: May 1, 2014

Facility response: Informational campaigns have been developed to educate all staff of the existing educational tools that address pressure ulcer prevention education for patients and caregivers and the importance of documenting provision of this education for patients at risk for and with existing pressure ulcers. Compliance with documentation of pressure ulcer education for patients with pressure ulcers and/or their caregivers will be routinely monitored weekly by unit nurse managers. The SWAT committee members will serve as unit resources towards this objective. Auditing results will be reported to the Medical Staff Executive Committee quarterly to ensure compliance is monitored.

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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*, October 15, 2012.
- 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.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] 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.

[6] 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.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.