Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00688-162

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

May 14, 2014

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Canandaigua VA Medical Center
FY	fiscal year
MADHC	mobile adult day health care
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
RRTP	residential rehabilitation treatment 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 March 24, 2014.

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

- Quality Management
- Medication Management – Controlled Substances Inspection Program
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishment was the Mobile Adult Day Health Care Outreach Program.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Ensure Environment of Care Work Group minutes reflect that actions are taken in response to identified deficiencies. Establish a policy for the safe use of fluoroscopic equipment. Ensure all designated x-ray/fluoroscopy employees receive annual fluoroscopy safety training.

Nurse Staffing: Include all required members on the facility expert panel.

Community Living Center Resident Independence and Dignity: Consistently document weekly and monthly restorative nursing notes according to local policy.

Management of Test Results: Ensure that providers are notified of critical laboratory and abnormal radiology test results/values within the expected timeframe and that patients are notified of normal test results/values within the expected timeframe. Document provider and patient notification of test results in the electronic health records.

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 consider recommendation 3 closed. We will follow up on the planned actions for the open recommendations 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 – CS Inspection Program
- Nurse Staffing
- CLC Resident Independence and Dignity
- MH RRTP
- Management of Test Results

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 March 21, 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 Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 10-00475-38, November 30, 2010).

During this review, we presented crime awareness briefings for 116 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 269 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 Accomplishment

MADHC Outreach Program

The MADHC Outreach Program was developed to support the needs of rural and suburban veterans by bringing meaningful adult day health care services closer to where veterans live. The program team, which consists of a certified therapeutic recreation specialist, a certified nursing assistant, and a recreation assistant, travels to four sites to deliver care consistent with a social model adult day health care program. The team provides assistance with some activities of daily living and provides therapeutic services designed to help participants with physical and mental functioning. A program manager oversees the coordination of the services for veterans and caregivers.

Since the program's start on June 6, 2010, through September 2013 there have been 260 veterans referred to the program. At the close of FY 2013, there were 66 veterans and 60 caregivers receiving services. The program was the regional recipient of the New York Organization of Nurse Executives 2011 Best Practice Award. In addition, the VA Office of Nursing Services selected the program as one of its Nursing Services Innovations Award recipients in 2011. The MADHC Program manager has assisted three VHA facilities with developing similar programs.

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. 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
	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
NA	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 re-assessed timely.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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.	
NA	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.	
NA	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
NA	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.	

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 three CLC units, the primary care and physical therapy clinics, and the radiology department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed eight radiology employee training records. 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 for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Work Group meeting minutes reviewed: • Minutes did not reflect that actions were taken in response to identified deficiencies.
	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.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
X	The facility had a policy for the safe use of fluoroscopic equipment.	• The facility did not have a policy for the safe use of fluoroscopic equipment.

NM	Areas Reviewed for General Radiology (continued)	Findings
	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.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA Handbook 1105.04 reviewed: • Seven of the eight x-ray/fluoroscopy employees did not receive annual fluoroscopy safety training.
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	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.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	

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

Recommendations

1. We recommended that processes be strengthened to ensure that EOC Work Group minutes reflect that actions are taken in response to identified deficiencies.

2. We recommended that the facility establish a policy for the safe use of fluoroscopic equipment and that compliance with the newly established policy be monitored.

3. We recommended that processes be strengthened to ensure that all designated x-ray/fluoroscopy employees receive annual fluoroscopy safety training.

Medication Management – CS Inspection Program

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 the CS Coordinators and 10 CS inspectors and inspection documentation from 6 CS areas, the pharmacies, and the emergency drug cache. 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
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	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.	
	CS inspectors were appointed in writing, were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	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 one long-term care inpatient unit.[4]

We reviewed facility and unit-based expert panel documents and 11 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 1 randomly selected unit—CLC unit 3A—for 50 randomly selected days between October 1, 2012, and September 30, 2013. 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.	
X	The facility expert panel followed the required processes and included the required members.	• The facility expert panel did not include direct patient care staff and evening and night supervisory staff.
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	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 the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

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.[5]

We reviewed 13 EHRs of residents (10 residents receiving restorative nursing services and 3 residents not receiving restorative nursing services but candidates for services). We also observed seven residents during two meal periods, reviewed six employee training/competency records and other relevant documents, and 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 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.	
	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.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility Restorative Nursing Program policy reviewed: • Restorative nursing staff did not consistently document weekly and monthly notes as required by local policy in any of the 10 applicable EHRs.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

5. We recommended that processes be strengthened to ensure that restorative nursing staff consistently document weekly and monthly notes according to local policy and that compliance be monitored.

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary and Psychiatric Residential Rehabilitation Program units complied with selected EOC requirements.[6]

We reviewed relevant documents, inspected two units, 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 residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Management of Test Results

The purpose of this review was to evaluate whether VHA facilities complied with selected requirements for managing test results.[7]

We reviewed relevant policies and procedures and the EHRs of 20 patients who had critical laboratory or abnormal radiology test results/values in FY 2013 (10 for laboratory and 10 for radiology). In addition, we reviewed the EHRs of 30 patients who had normal laboratory, radiology, or Pap smear results/values. We also conversed with key employees. 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 written policy or guideline that addressed the management of critical/abnormal test results/values, and compliance was monitored.	
X	Providers were notified of critical/abnormal test results/values by appropriate staff within the expected timeframe.	• Three of the 10 EHRs of patients with critical laboratory results/values did not contain documentation of provider notification within the facility's expected timeframe of 30 minutes. • Six of the nine applicable EHRs of patients with abnormal radiology results/values did not contain documentation of provider notification within the facility's expected timeframe of 30 minutes.
	Patients were notified of critical/abnormal test results/values within the expected timeframe and by the approved method of communication.	
	Follow-up actions were taken in response to critical/abnormal test results/values.	
X	Patients were notified of normal test results/values within the expected timeframe.	• Twelve of the applicable 30 EHRs (40 percent) did not contain documentation of patient notification of normal test results/values. • Three of the applicable 18 EHRs did not contain documentation of patient notification within 14 days.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

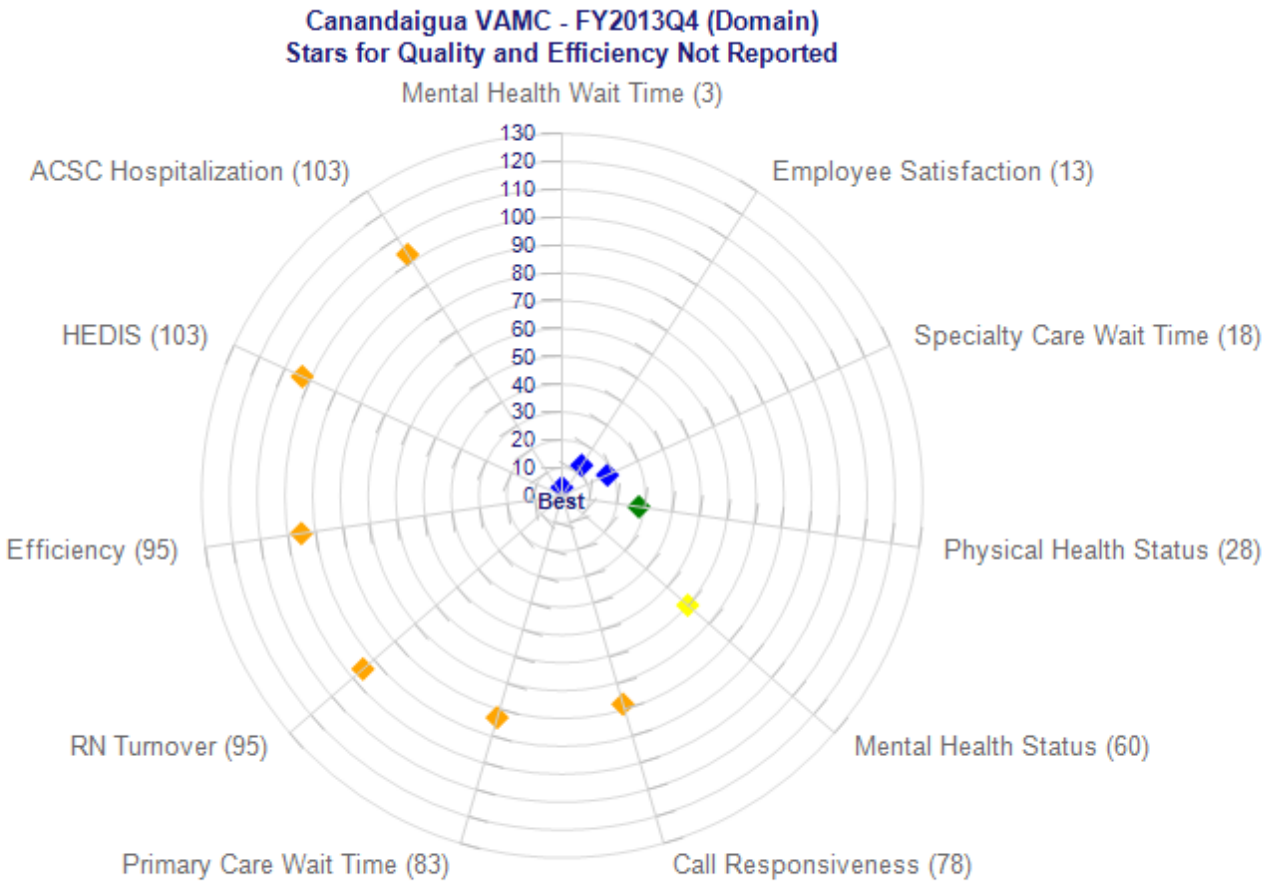
6. We recommended that processes be strengthened to ensure that providers are notified of critical laboratory and abnormal radiology test results/values within the expected timeframe and that notification is documented in the EHRs.

7. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the EHRs.

Facility Profile (Canandaigua/528A5) FY 2014 through March 2014[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$107.8
Number of:	
• **Unique Patients**	14,145
• **Outpatient Visits**	79,662
• **Unique Employees**[b]	896
Type and Number of Operating Beds (December 2013):	
• **Hospital**	NA
• **CLC**	138
• **MH**	80
Average Daily Census (January 2014):	
• **Hospital**	NA
• **CLC**	102
• **MH**	44
Number of Community Based Outpatient Clinics	1
Location(s)/Station Number(s)	Rochester/528GE
VISN Number	2

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

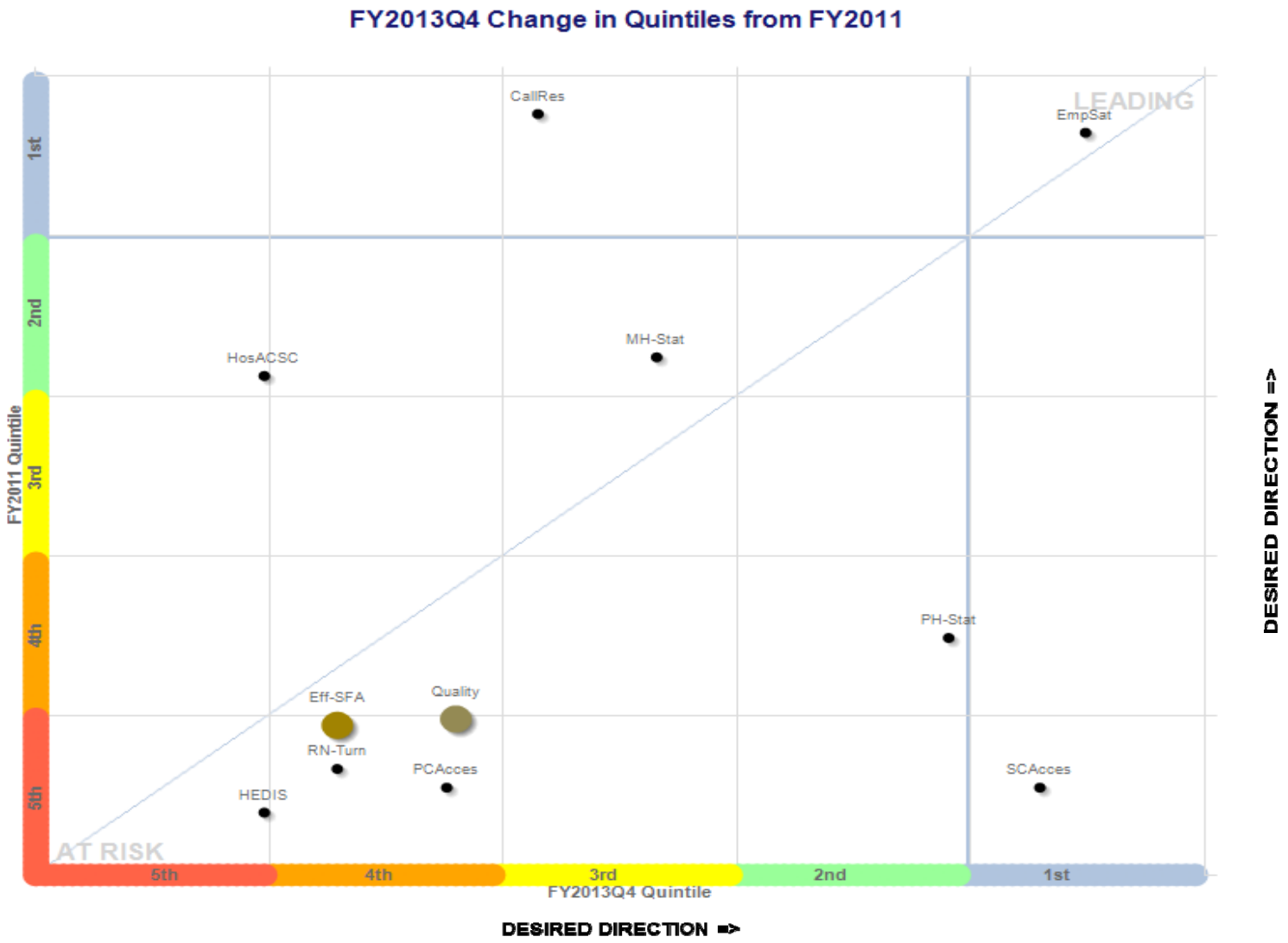
Strategic Analytics for Improvement and Learning (SAIL)[c]



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

Appendix C

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2014

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

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

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

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

1. We are submitting written comments in response to the CAP Review of the Canandaigua VA Medical Center completed March 24–27, 2014, in Canandaigua, New York.

2. In reviewing the draft report, the facility addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 2 concurs with the report.

3. If you have any questions regarding this response, please contact Karen Strobel, VISN 2 Quality Management Officer, (518) 626-7325.

Darlene A. DeLancey, MS

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2014

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

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

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

1. We are submitting written comments in response to the CAP Review of the Canandaigua VA Medical Center completed March 24–27, 2014, in Canandaigua, New York.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. I concur with the report.

3. If you have any questions regarding this response, please contact Paula LeGrett, Quality Manager at (585) 393-7573.

Craig S. Howard

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 EOC Work Group minutes reflect that actions are taken in response to identified deficiencies.

Concur

Target date for completion: April 30, 2014

Facility response: Members of the EOC Rounds Work Group will be trained on the use of a new automated system designed to report deficiencies and track progress through an action plan log to ensure ongoing tracking and trending of actions through closure.

Improved reporting to EOC Committee will include a spreadsheet with itemized information on every inspected area including, the total number of deficiencies found, the open deficiencies for the department, the number of days left to complete the open deficiencies, and responsible party(s) for each deficiency. Auditing reports will be reported to the EOC Committee monthly to ensure compliance is monitored through closure.

Recommendation 2. We recommended that the facility establish a policy for the safe use of fluoroscopic equipment and that compliance with the newly established policy be monitored.

Concur

Target date for completion: May 25, 2014

Facility response: A new Facility Radiation and Fluoroscopy Safety policy was developed. Compliance with the newly established policy will be monitored by the Radiology Chief and through Radiology Department minutes. Auditing results will be reported to The Executive Committee for Medical Staff quarterly to ensure compliance is monitored.

Recommendation 3. We recommended that processes be strengthened to ensure that all designated x-ray/fluoroscopy employees receive annual fluoroscopy safety training.

Concur

Target date for completion: April 25, 2014

Facility response: All radiology staff have completed the mandatory annual fluoroscopy safety training provided through the TMS course Item VA 1332023, "V02 X-Ray Radiation Safety. Chief of Radiology will monitor staff TMS Compliance/Deficiency Reports to ensure annual training.

Recommendation 4. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Concur

Target date for completion: May 1, 2014

Facility response: The Facility Expert Panel for FY 14 will include all the required members as follows: Direct care staff nurses, Associate Chief Nurse for Geriatrics, evening and night supervisory staff, Geriatric Nurse Managers, Fiscal personnel. Associate Chief Nurse for Patient Care Services (ADPNS) will ensure additional members have been added.

Recommendation 5. We recommended that processes be strengthened to ensure that restorative nursing staff consistently document weekly and monthly notes according to local policy and that compliance be monitored.

Concur

Target date for completion: April 18, 2014

Facility response: Medical Center Policy for the Restorative Nursing Program has been revised to require monthly documentation. Education was provided to all Community Living Center Registered Nurses on this changed documentation requirement. Compliance will be monitored by the Restorative Nurse Manager and MDS Coordinator monthly. Auditing results will be reported to the Executive Committee for Nursing Staff monthly to ensure compliance is monitored.

Recommendation 6. We recommended that processes be strengthened to ensure that providers are notified of critical laboratory and abnormal radiology test results/values within the expected timeframe and that notification is documented in the EHRs.

Concur

Target date for completion: May 30, 2014

Facility response: Facility policy is being revised to ensure critical results are transmitted immediately by direct communication to the ordering provider and appropriately documented in the EHR. If the ordering practitioner is not available, communication will be made to a surrogate practitioner. When both ordering and surrogate practitioners are not available, a process will be in place for the communication of results to another practitioner who can take action. Monitoring will be ongoing to ensure performance within the expected timeframes and that notification is documented in the EHR.

Auditing results will be reported to the Executive Committee for Medical Staff monthly to ensure compliance is monitored.

Recommendation 7. We recommended that processes be strengthened to ensure that all patients are notified of normal test results/values within the expected timeframe and that notification is documented in the EHRs.

Concur

Target date for completion: May 30, 2014

Facility response: Standardized note template has been implemented to strengthen the notification of normal test results/values within the expected timeframes and that notification is documented in the EHR. This templated note will be the required documentation process for non-face to face notification of results to patients. Face to face communication is documented at the time of visit. Monitoring will be by clinical chiefs in the ongoing professional practice evaluations chart reviews quarterly and by the medical records committee for aggregate review. Auditing results will be reported to the Executive Committee for Medical Staff monthly to ensure compliance is monitored.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Annette Acosta, RN, MN, Team Leader Elaine Kahigian, RN, JD Frank Keslof, EMT, MHA Jeanne Martin, PharmD Christopher Barlow, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Matt Frazier, MPH Jeff Joppie, BS Victor Rhee, MHS Julie Watrous, RN, MS Jarvis Yu, MS

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Endnotes

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