Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04210-63

Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, New York

January 14, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Samuel S. Stratton VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCAN ECHO	Specialty Care Access Network/Extension for Community Healthcare Outcomes
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 October 6, 2014.

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

- Surgical Complexity

The facility's reported accomplishment was the implementation of the Specialty Care Access Network/Extension for Community Healthcare Outcomes.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure the Medical Executive Committee and the Facility Director consistently review and approve revised privilege forms. Reassess observation criteria and utilization when conversions from observation bed status to acute admissions exceed benchmarks. Ensure the Critical Care Committee reviews each code episode and associated clinical issues and consistently collects code data. Require the Surgical Work Group to meet monthly. Share patient handling injury data.

Environment of Care: Ensure patient care area floors and restrooms are clean. Repair damaged floors and wall surfaces. Repair damaged wheelchairs and furnishings in patient care areas, or remove them from service. Ensure all required members of the Environment of Care Committee consistently attend meetings.

Medication Management: Use special medication labeling and/or institute unique storage practices for the complete list of look-alike and sound-alike medications. Consistently complete monthly medication storage area inspections. Require that oral syringes are available for liquid medications and are stored separately from parenteral syringes. Revise the local inspection policy on inspection of medication storage areas to be consistent with Veterans Integrated Service Network policy.

Coordination of Care: Ensure major bed services have designated Automated Data Processing Application Coordinators.

Magnetic Resonance Imaging Safety: Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the three inpatient units and in the two community living centers. Screen patients for difficulty swallowing prior to oral intake, and provide printed stroke education to patients upon discharge. Ensure

employees involved in assessing and treating stroke patients receive the required training. Report stroke quality indicator data to the Veterans Health Administration.

Emergency Airway Management: Ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and evidence of successful demonstration of all required procedural skills.

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 26–35, for the full text of the Directors' comments.) We consider recommendation 17 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
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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 eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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 2013 and FY 2014 through August 25, 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 Samuel S. Stratton VA Medical Center, Albany, New York,* Report No. 11-03664-88, February 16, 2012). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 103 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 325 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

SCAN ECHO Program

SCAN ECHO is a VHA initiative to improve access to specialty care services. The program provides clinical training, specialty care consultation, and clinical support from specialty care teams to outpatient primary care providers using video teleconferencing equipment. After receiving a consult request from a primary care provider, the specialty SCAN ECHO team will meet with the provider by video to discuss the case. Everyone participates in the discussion to understand the critical thinking that goes into the final treatment recommendations. The facility started a SCAN ECHO program in October 2013 and added palliative medicine and dementia/neurodegenerative disease specialties to the program in 2014. The facility was the first in VHA to add the palliative medicine specialty. In FY 2014, the facility's team developed a SCAN ECHO program for VISN 2.

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.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• The Medical Executive Committee and the Facility Director had not reviewed and approved three revised privilege forms.	**1.** We recommended that the Medical Executive Committee and the Facility Director consistently review and approve revised privilege forms.
X	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.	Twelve months of data reviewed: • For 6 months, the facility converted more than 25–30 percent of observation patients to acute admissions and did not reassess observation criteria or utilization during that time.	**2.** We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassess observation criteria and utilization.
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.	Twelve months of Critical Care Committee meeting minutes reviewed: • The committee did not review each episode. • Code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code. • The facility did not collect performance data.	**3.** We recommended that the Critical Care Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee consistently collect code performance data.

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met five times over the past 12 months.	**4.** We recommended that the Surgical Work Group meet monthly.
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	Twelve months of Safe Patient Handling Committee meeting minutes reviewed: • The committee did not share patient handling injury data.	**5.** We recommended that the facility share patient handling injury data.
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors. • A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM 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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the behavioral health, critical care, telemetry, and medical/surgical units and two CLC inpatient units. We also inspected the ED, the specialty clinic, and two primary care clinics. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 30 employee training records (10 critical care and 20 CLC) and conversed with key employees and managers. 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	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Floors needed cleaning in five of seven patient care areas and in three public restrooms. Cleanliness was a repeat finding from the previous CAP review. • In three of seven patient care areas, we found damaged floor tiles and damaged wall surfaces. • We found damaged furnishings or wheelchairs in three of seven patient care areas.	**6.** We recommended that facility managers ensure patient care area floors and public restrooms are clean and monitor compliance. **7.** We recommended that the facility repair damaged floors and wall surfaces in patient care areas. **8.** We recommended that the facility repair damaged wheelchairs and furnishings in patient care areas or remove them from service.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met auditory privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy and EOC Committee meeting minutes for FY 2014 reviewed: • Twelve of 30 members of the EOC committee had limited or no attendance at committee meetings.	**9.** We recommended that facility managers ensure all required members of the Environment of Care Committee consistently attend meetings and monitor compliance.
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met fire safety requirements in critical care.		
X	The facility met environmental safety requirements in critical care.	• We found damaged furnishings in the critical care area.	See recommendation 8.
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met patient privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• We found damaged furnishings in one of two patient care areas.	See recommendation 8.
	The facility met infection prevention requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected a medical/surgical unit, the intensive care unit, the ED, and a CLC and for these areas reviewed documentation of overrides and narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.	• The facility did not use special medication labeling and/or institute unique storage practices for the complete list of look-alike and sound-alike medications.	**10.** We recommended that the facility use special medication labeling and/or institute unique storage practices for the complete list of look-alike and sound-alike medications and that facility managers monitor compliance.
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The medical/surgical unit, intensive care unit, ED, and CLC all had one or more missed monthly medication storage area inspections.	**11.** We recommended that facility managers ensure monthly medication storage area inspections are consistently completed and monitor compliance.
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
X	The facility employed practices to prevent wrong-route drug errors.	• On the medical/surgical unit and intensive care unit and in the CLC and ED, oral syringes were not available for staff to administer liquid oral medications when dose amounts differed from the unit dose packages supplied, and staff reported they used parenteral syringes.	**12.** We recommended that facility managers ensure that oral syringes are available for oral liquid medication administration and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
X	The facility complied with any additional elements required by VHA, VISN, or local policy.	VISN policy on inspection of medication storage areas reviewed: • VISN policy required monthly inspection of all drug storage and medication areas on nursing units and in facility clinics; however, local policy did not comply with VISN policy.	**13.** We recommended that the facility revise the local policy on inspection of medication storage areas to be consistent with Veterans Integrated Service Network policy.

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. 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	Recommendations
	A committee oversaw the facility's consult management processes.		
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	• Major bed services did not have Automated Data Processing Applications Coordinators.	**14.** We recommended that major bed services have designated Automated Data Processing Applications Coordinators.
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors properly titled the requests. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 42 employees (30 randomly selected Level 1 ancillary staff and 12 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. 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	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• None of the Level 1 ancillary staff received level-specific annual MRI safety training.	**15.** We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 31 randomly selected patients who experienced stroke symptoms, and three Medical Service employee training records, and we conversed with key employees. We also conducted onsite inspections of the ED, the critical care unit, two acute inpatient units, two CLCs, and the inpatient behavioral health unit. 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	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 12 of the 31 patients (39 percent), clinicians did not document evidence of completed stroke scales.	**16.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines on three inpatient units and in the two CLCs.	**17.** We recommended that facility managers post stroke guidelines on the three inpatient units and in the two community living centers.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For eight of the 26 applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**18.** We recommended that clinicians screen patients for difficulty swallowing, that screening be done prior to oral intake, and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided printed stroke education to patients upon discharge.	• For 12 of the 20 applicable patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**19.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• Two employees' training records did not contain documented evidence of re-certification for the National Institutes of Health stroke scale.	**20.** We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.
X	The facility collected and reported required data related to stroke care.	• The facility did not report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**21.** We recommended that the facility report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to their assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 14 employees, and we conversed with key managers and 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	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 12 clinicians, and we conversed with key managers and 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.

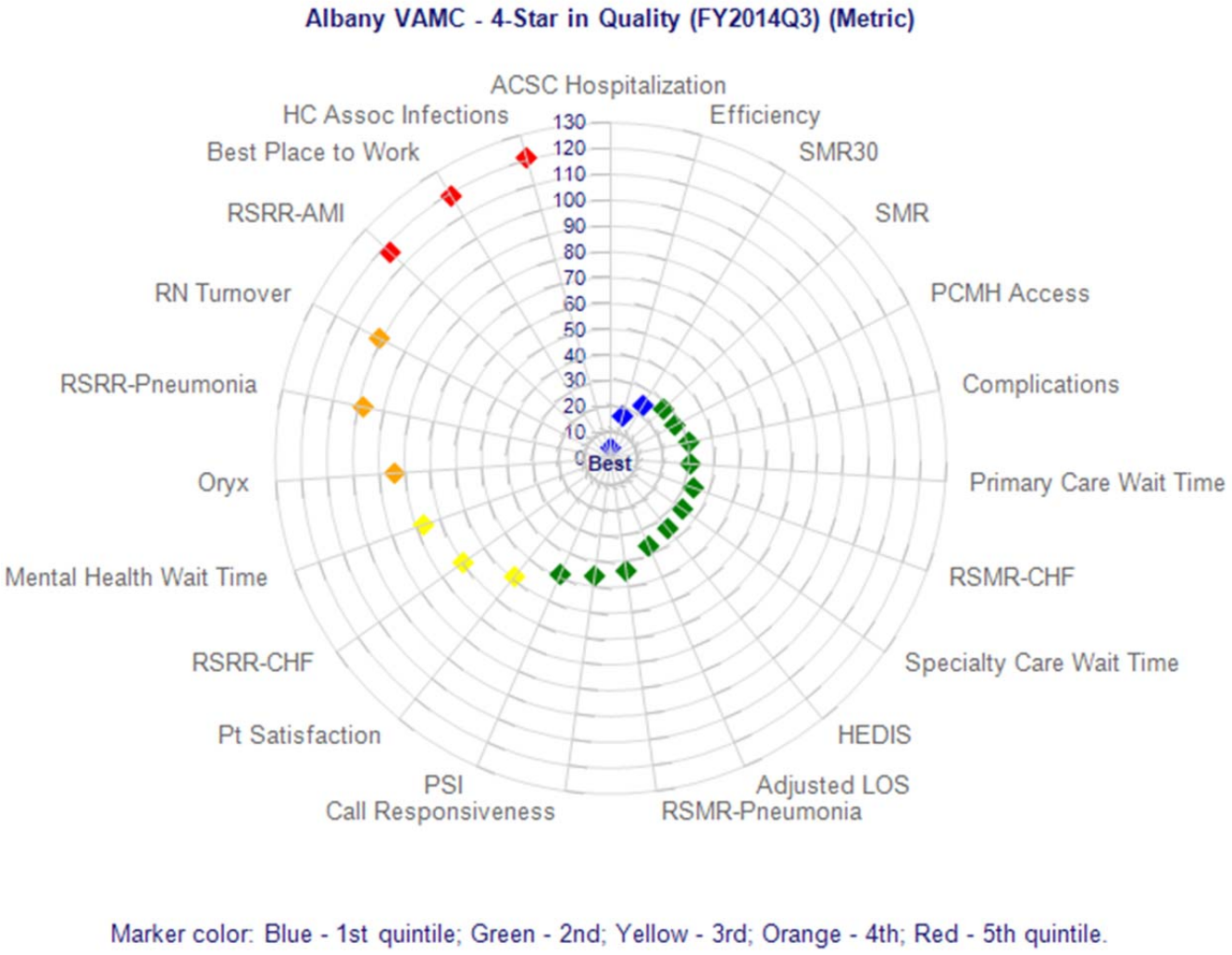
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the 11 clinicians with reassessments for continued EAM competency had documentation of all required subject matter content elements. • None of the 11 clinicians with reassessments for continued EAM competency had evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.	**22.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and that facility managers monitor compliance. **23.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Albany/528A8) FY 2014[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Billions for VISN 2	$1.12
Number of:	
• **Unique Patients**	37,294
• **Outpatient Visits**	398,693
• **Unique Employees**[2]	1,168
Type and Number of Operating Beds (as of August):	
• **Hospital**	81
• **CLC**	50
• **MH**	12
Average Daily Census (as of August):	
• **Hospital**	44
• **CLC**	47
• **MH**	9
Number of Community Based Outpatient Clinics	11
Location(s)/Station Number(s)	Malone/528G1 Westport/528G2 Bainbridge/528G3 Fonda/528G6 Catskill/528G7 Glens Falls/528GT Plattsburgh/528GV Schenectady/528GW Troy/528GX Clifton Park/528GY Kingston/528GZ
VISN Number	2

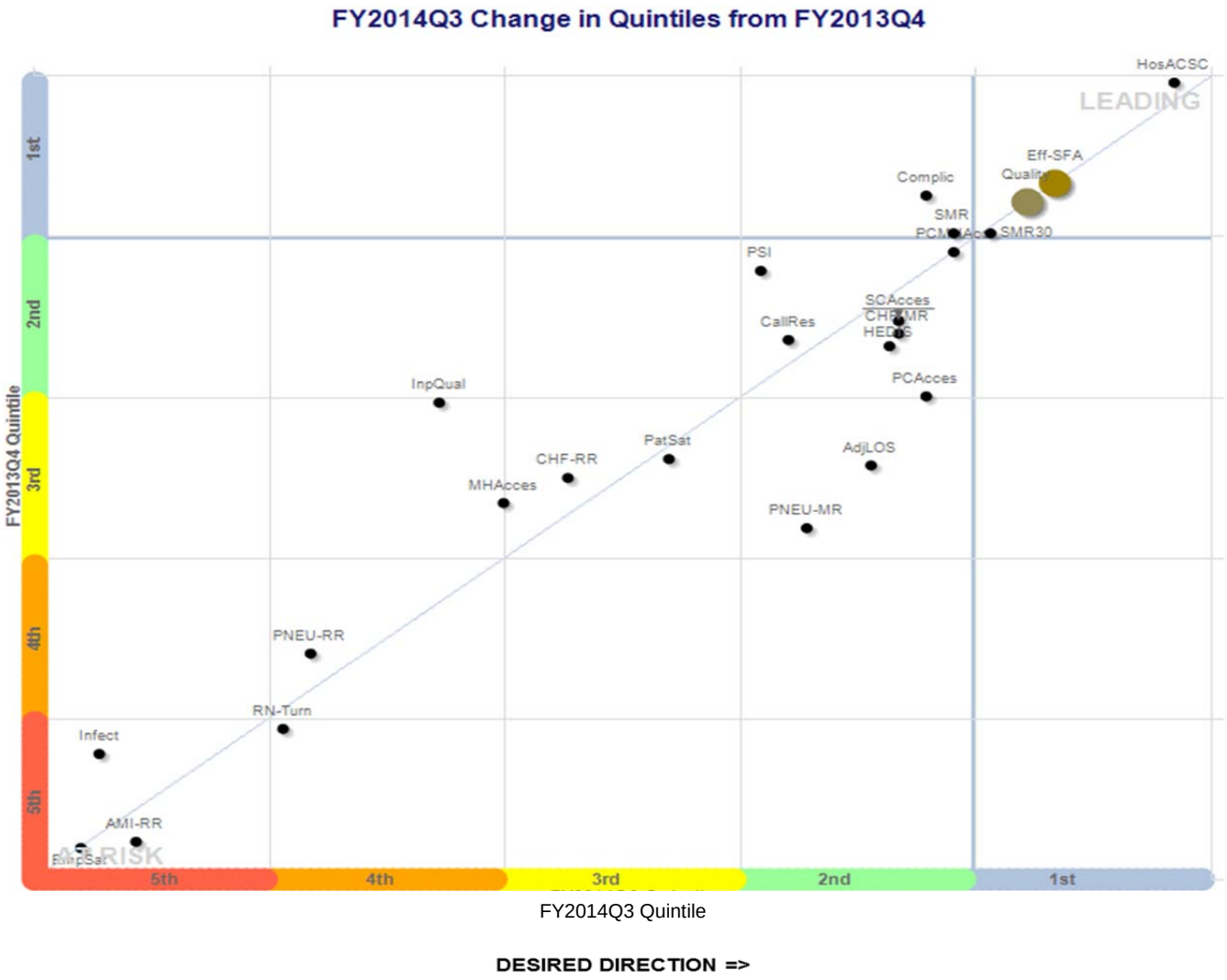
[1] All data is for FY 2014 through the end of the FY except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] 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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 1, 2014

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

Subject: **CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

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

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

I concur with the recommendations listed in the Office of Inspector General's report, Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, New York.

(original signed by:)
Darlene A. DeLancey, MS

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 28, 2014

From: Director, Samuel S. Stratton VA Medical Center (528A8/00)

Subject: **CAP Review of the Samuel S. Stratton VA Medical Center, Albany, NY**

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

I concur with the recommendations listed in the Office of Inspector General's report, Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, New York.

(original signed by:)
LINDA W. WEISS, MS, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Medical Executive Committee and the Facility Director consistently review and approve revised privilege forms.

Concur

Target date for completion: March 2, 2015

Facility response: Revised privilege forms will be reviewed and documented in Professional Standards Board and the Executive Committee of the Medical Staff meeting minutes. These minutes will be signed by the Chief of Staff and the Medical Center Director.

Recommendation 2. We recommended that when conversions from observation bed status to acute admissions are 25–30 percent or more, the facility reassess observation criteria and utilization.

Concur

Target date for completion: April 1, 2015

Facility response: Utilization Management will monitor and report observation status for acute admissions monthly to the Executive Committee of the Medical Staff meeting. If conversion rate reaches 25% or more, the Executive Committee of the Medical Staff will assign review and reassessment of observation criteria. Review will be conducted by Utilization Management and assessed for improvement by The Executive Committee of the Medical Staff at the next monthly meeting.

Recommendation 3. We recommended that the Critical Care Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee consistently collect code performance data.

Concur

Target date for completion: March 2, 2015

Facility response: The Code Blue Committee has been reviewing each code blue including clinical history. Data is collected, summarized and analyzed by the code blue committee. Documentation of code analysis is now a monthly standing agenda item in the Critical Care Committee beginning with the November 2014 meeting. This Data will

be reported quarterly as well as annually to the Executive Committee of the Medical Staff.

Recommendation 4. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: February 2, 2015

Facility response: Regular monthly meetings have been scheduled for the facility Surgical Work Group for all of FY2015 and will be a recurring monthly meeting in the following years.

Recommendation 5. We recommended that the facility share patient handling injury data.

Concur

Target date for completion: January 5, 2015

Facility response: The Safe Patient Handling Coordinator conducts monthly meetings with the Unit Peer Leader Committee to review and trend the Accident Review Board data in regards to staff injuries. The Safe Patient Handling Coordinator will review with the Unit Peer Leaders pertinent desensitized injury data quarterly and analyze for trends. The Unit Peer Leaders will then report the analysis of the data to the unit staff. The Safe Patient Handling Coordinator will also report outcomes quarterly to the Accident Review Board.

Recommendation 6. We recommended that facility managers ensure patient care area floors and public restrooms are clean and monitor compliance.

Concur

Target date for completion: February 1, 2015

Facility response: Areas identified by the OIG inspectors have been deep cleaned. The Chief of Environmental Management Services and Infection Prevention staff is currently developing a framework for compliance and will be monitored and reported monthly to the Executive Committee of the Medical Staff. The framework will include feedback from staff, Veterans and Environmental Management Service supervisors. Additionally, the Environment of Care rounds will continue weekly to identify areas of need. A Risk based approach will be used for prioritizing areas to determine task and frequency of cleaning. Areas will be identified based on risk from most critical to least critical patient care areas.

Recommendation 7. We recommended that the facility repair damaged floors and wall surfaces in patient care areas.

Concur

Target date for completion: January 15, 2015

Facility response: Areas identified by the OIG inspectors are currently being repaired. 23 areas were identified, 90% are complete. Currently the area managers submit work orders to initiate repairs. Emergency Management Service and Facility Management Service will address electronic work orders according by work order system priority. Environment of Care will require that work orders will be reported monthly to the Environment of Care committee and then to Leadership Council quarterly.

Recommendation 8. We recommended that the facility repair damaged wheelchairs and furnishings in patient care areas or remove them from service.

Concur

Target date for completion: January 15, 2015

Facility response: Items identified as damaged by the OIG inspector were removed from service immediately. As of November 1, 2014, area managers will remove items from service and submit work orders to facilitate repairs. Emergency Management Service and Facility Management Service will address electronic work orders according by work order system priority. Work orders will be reported monthly to the Environment of Care Committee and then to Leadership Council Committee quarterly.

Recommendation 9. We recommended that facility managers ensure all required members of the Environment of Care Committee consistently attend meetings and monitor compliance.

Concur

Target date for completion: March 1, 2015

Facility response: The Committee Charter and Standard Operating Procedure are currently being restructured for the Environment of Care Committee to reflect a change in the required members needed for a quorum. The attendees will be reviewed by the Environment of Care co-chairs monthly for compliance. All seven program managers will be required to attend or designate an alternate.

Recommendation 10. We recommended that the facility use special medication labeling and/or institute unique storage practices for the complete list of look-alike and sound-alike medications and that facility managers monitor compliance.

Concur

Target date for completion: January 15, 2015

Facility response: Name alerts for look-alike, sound-alike medications are in place in the pharmacy where these medications are stored. For the nursing units, Pharmacy will re-enter the drug profile in Pyxis to utilize tall man lettering for all Look Alike/Sound Alike medications. The Pyxis drug profile update is in process.

Recommendation 11. We recommended that facility managers ensure monthly medication storage area inspections are consistently completed and monitor compliance.

Concur

Target date for completion: April 2, 2015

Facility response: The VAMC is implementing a new electronic inspection form process that will allow both the pharmacy technician and the nurse representative for the ward inspection area to sign the electronic form. This will ensure efficient storage and retrieval of ward inspections. The inpatient and outpatient pharmacy supervisors will review the electronic ward inspections assigned to their work groups monthly. They will document via memo that the ward inspections for the month have been completed and identify any actions that were taken to resolve problematic findings. These memos will be included in the electronic ward inspection file.

Recommendation 12. We recommended that facility managers ensure that oral syringes are available for oral liquid medication administration and that they are stored separately from parenteral syringes to minimize the risk of wrong-route medication errors.

Concur

Target date for completion: February 27, 2015

Facility response: The Logistics Chief has initiated the process to provide oral syringes used for dosing liquid medications for in-patients. Once the process is completed and the syringes are delivered, the syringes will be stored separately in the Logistic supply rooms to minimize wrong-route medication errors. The Nurse Managers will educate the nursing staff on the location and proper use of the oral syringes.

Recommendation 13. We recommended that the facility revise the local policy on inspection of medication storage areas to be consistent with Veterans Integrated Service Network policy.

Concur

Target date for completion: February 27, 2015

Facility response: The VAMC local policy, Procedures for Processing, Distribution and Inspection of Ward/Clinic Stock Medications is being re-drafted to include local ward inspections and measures required to monitor consistency with completing inspections. The ward inspection results will be reported to the Medication Use Committee starting with the January 2015 meeting.

Recommendation 14. We recommended that major bed services have designated Automated Data Processing Applications Coordinators.

Concur

Target date for completion: December 12, 2014

Facility response: The VAMC Care Line Administrative Officers have been designated as the Automated Data Processing Applications Coordinators for their respective Care Lines.

Recommendation 15. We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: December 15, 2014

Facility response: All hospital staff has been assigned the appropriate Magnetic resonance imaging safety training in the Talent Management System and this was incorporated into mandatory Talent Management System training.

Recommendation 16. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Medical Staff have been re-educated on completion and entry of National Institutes of Health stroke scales (NIHSS) in medical record as directed by guideline for all Veterans referred for Acute Ischemic Stroke. This re-education was

completed as of November 25, 2014. The Stroke Committee will monitor compliance for completion of the NIHSS scale by chart audits and will report quarterly to the Executive Committee of the Medical Staff.

Recommendation 17. We recommended that facility managers post stroke guidelines on the three inpatient units and in the two community living centers.

Concur

Target date for completion: November 3, 2014

Facility response: All area managers have posted the stroke guidelines in the three in-patient units, the Emergency Department and in the two community living centers as of November 3, 2014.

Recommendation 18. We recommended that clinicians screen patients for difficulty swallowing, that screening be done prior to oral intake, and that facility managers monitor compliance.

Concur

Target date for completion: April 15, 2015

Facility response: The Unit Managers and Supervisors will re-educate staff on screening patients prior to oral intake. This documentation of screening will be monitored by the stroke committee for compliance through chart audits and reported quarterly to the Executive Committee of the Medical Staff.

Recommendation 19. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: February 27, 2015

Facility response: Educational material on stroke and transient ischemic attack will be obtained from Computerized Patient Record System utilizing informed medical consent education (iMED). All Emergency room and Intensive care clinical staff will be trained on this education material by the unit managers. The documentation of education will be audited and reported monthly to the Stroke Committee and reported quarterly to Executive Committee of the Medical Staff.

Recommendation 20. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2015

Facility response: Certification/Re-certification on the performance of the National Institutes of Health stroke scales will be completed for all providers in the Neurology Service. This will be reviewed bi-annually by the Chief of Neurology for compliance.

Recommendation 21. We recommended that the facility report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: April 1, 2015

Facility response: A process for collecting and entering data has been established, utilizing the VA Inpatient Evaluation Center (IPEC) system. The data from the IPEC system will be audited and reported monthly to the Stroke Committee and then reported quarterly to Executive Committee of the Medical Staff.

Recommendation 22. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and that facility managers monitor compliance.

Concur

Target date for completion: March 2, 2015

Facility response: Assignment of the Talent Management System component of OOORAM/EAM (Talent Management System Item VA 16087-Out of Operating Room Airway Management Provider Didactic) to each provider as specified by facility policy for Out of Operating Room Airway Management. This will be re-assessed bi-annually by the Chief of Anesthesia. Documentation for training, skills, and competency will be kept on a secured shared drive maintained jointly by the Chief of Anesthesia, the Chief of Respiratory Therapy and the Chief of Pulmonary Medicine.

Recommendation 23. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

Concur

Target date for completion: March 2, 2015

Facility response: Competency demonstration will be completed with each provider for all the required procedural skills on airway simulators or mannequins as specified by facility policy for Out of Operating Room Airway Management. This will be re-assessed bi-annually by the Chief of Anesthesia. Documentation for training, skills, and competency will be kept on a secured shared drive maintained jointly by the Chief of Anesthesia, the Chief of Respiratory Therapy and the Chief of Pulmonary Medicine.

Office of Inspector General
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This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, Anticoagulation Therapy Management, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.