Department of Veterans Affairs

Memorandum

Date: December 20, 2010

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

Subj: Administrative Closure - Hotline Case Number 2011-01025-HI-0047

To: Assistant Inspector General for Healthcare Inspections (54)

The OIG received allegations regarding a number of ongoing problems on the 4th Floor of the Manhattan Campus of the VA New York Harbor Health Care System (the facility). In September 2010, the Hotline Division referred the list of eight allegations to the facility to address. On November 9, 2010, the facility submitted its response, which satisfactorily addressed six of the eight allegations. However, the facility provided only vague responses on two of the allegations (#1 and #3), and OHI Hotline Management Division requested that the Bedford Office follow up.

Allegation #1 - Inadequate air conditioning causing delays of surgical procedures requiring cool temperatures for myocardial preservation.

For this allegation, we requested documentation from the facility for the period July 1, 2010 through October 31, 2010. Based on our review, we did not substantiate the allegation. Although there were a few instances of delays, we did not identify a pattern of delays due to temperature or humidity problems in the OR suite.

- The facility uses an automated 24-hour monitoring system for temperature and humidity throughout the OR suite. Our review of a random sample of the graphic display records for the period showed temperature and humidity to be within acceptable limits for the majority of the time.
- There were seven incident reports documented during the period; our review found that none were related to delays or cancellations, nor were any of them related to problems with environmental systems.
- The facility maintains a comprehensive recordkeeping system to track cancellations and delays in the OR suite and the reasons they occur. We reviewed all cancellations and delays for the 4-month period, during which there was a total of 70 cardiac procedures. There were no cancellations and only two delays of cardiac procedures attributed to temperature problems in the OR. These were the only temperature-related delays throughout the entire department during the period reviewed. Delays were mostly related to patient conditions, staff availability, or pre-empting of the OR suite for more serious cases.
- We reviewed copies of all repair requests by OR staff and work orders for the period and found four instances when engineering staff were asked to make adjustments to the cooling system because temperatures were elevated.

- The facility reported that there were no complaints filed by surgeons, the anesthesia department, patients, or patient family members related to environmental conditions in the OR suite causing delays in procedures.

Allegation #3 – Severe and chronic shortage of Health Care Technicians (HT), which led to four patient falls out of bed due to poor staffing.

For this allegation, we requested the following documents from the facility: a job description for the HT, a unit and staffing profile for Unit 4 West, the falls/incident report aggregate for the past 2 quarters, the unit's staffing for the past quarter, and the most recent policy concerning patients at risk for falls. We then analyzed and trended the collected information and found that the evidence obtained from the facility and our review did not substantiate the allegation. Though the HT was not present in almost 50 percent of the shifts reviewed, enough experienced staff was available to cover the unit based on a patient census that rarely met full capacity. The patient fall rates for this unit and other units in the hospital did indicate that the rate exceeded the facility's goal/benchmark. However, there were indications that the facility was actively working to reduce the fall rate and had made some progress in accomplishing this.

- The job description for the HT defines this role as generally respiratory and cardiac related. This role requires abilities that could be assumed by an RN.
- The profile for the 4 West Unit states that this is a Telemetry/Surgical Unit with a full capacity of 25 patients; the average daily census is 21. The Unit uses a modified primary care model whereby the patients are assigned to RNs who are responsible for patient treatments, medications, orders, patient education, wound/ostomy care, tracheostomy care, and any other therapy needed. Minimum staffing for this Unit at full capacity is generally three RNs, three (two) NAs, and one HT for a total of 6–7 experienced staff per shift.
- A review of staffing for the past quarter showed that for the 2010 4th quarter 136 (49 percent) out of 276 shifts did not have a HT working.
- An analysis of daily patient census and staffing showed that though staffing of 56 shifts dropped below the minimum level set for a full patient census (25), the staffing was proportionate in relationship to the actual shift census.
- The incidence of patient falls and the patient fall rate had actually decreased in this unit from 2009 to 2010, and the rate between the 3rd and 4th quarter of 2010 had decreased from 4.78 to 3.37.

Based on the review of the additional documentation we requested from the facility, we concluded that allegations #1 and #3 were not substantiated. We recommend that this hotline be closed.

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CLAIRE McDONALD
Regional Director
Bedford Office of Healthcare Inspections

JOHN D. DAIGH, Jr., MD
Assistant Inspector General
for Healthcare Inspections