Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04211-94

Combined Assessment Program Review of the VA Hudson Valley Health Care System Montrose, New York

February 4, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AIS	acute ischemic stroke
CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Hudson Valley Health Care System
FY	fiscal year
IP	infection prevention
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PTSD	post-traumatic stress disorder
QM	quality management
RRTP	residential rehabilitation treatment program
UCC	urgent care clinic
VHA	Veterans Health Administration

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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 November 3, 2014.

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

- Coordination of Care
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishments were receiving national recognition and distinction from The Joint Commission's Top Performer on Key Quality Measures® program and establishing a Registered Nurse Transition Care Management Program.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure licensed independent practitioners trained to perform airway management are fully privileged. Complete the conversion from the six-part credentialing and privileging folder to the two-part privileging folder. Ensure that the Emergency Response Committee documents review of each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Environment of Care: Ensure public restrooms are free of insects. Clean and/or repair dirty/damaged wheelchairs in patient care areas or remove them from service. Ensure walk-off sticky mats are in place at construction site entrances, and secure site entrances.

Medication Management: Do not stock heparin in concentrations of more than 5,000 units per milliliter in patient care areas, or document approval by the Chief of Pharmacy. Revise the plan for safe use of automated dispensing machines to include oversight of overrides. Store medications awaiting destruction separately from medications available for administration.

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

Acute Ischemic Stroke Care: Revise the stroke policy to address all required items, and fully implement the revised policy. Complete and document National Institutes of Health Stroke scales for each stroke patient. Collect and report all required data elements to the Veterans Health Administration.

Emergency Airway Management: Comply with the appropriate Veterans Health Administration policy requirements. Revise the emergency airway management policy to include a plan for managing a difficult airway. Ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients. Require that a provider with completed emergency airway management privileges or a clinician with completed emergency airway management scope of practice is available during all hours the facility provides patient care. Ensure video laryngoscopes are available in all designated locations. Initiate actions to minimize a repeat occurrence in which a non-privileged provider performs an intubation and if this does occur, initiate a root cause analysis.

Comments

The Acting 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 28–36, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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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
- AIS Care
- EAM
- MH RRTP

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, FY 2014, and FY 2015 through November 6, 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 VA Hudson Valley Health Care System, Montrose, New York,* Report No. 11-03656-89, February 17, 2012).

During this review, we presented crime awareness briefings for 215 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 387 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

The JC's Top Performer on Key Quality Measures® Program

The facility earned the distinction of Top Performer on Key Quality Measures® and national recognition by The JC for attaining and sustaining excellence in accountability measure performance. The JC's program is based on data reported in the previous year about evidence-based clinical processes that are shown to be the best treatments for certain conditions, including heart attack, heart failure, pneumonia, inpatient MH services, and immunization. The facility earned this award in 3 consecutive years for its pneumonia care in 2011, hospital-based inpatient MH care in 2012, and hospital-based inpatient and immunization care in 2013.

Registered Nurse Transition Care Management Program

The facility established a Registered Nurse Transition Care Management Program designed to assist and coach veterans who are 65 or older with the transition of care from community hospitals to the next level of care within the community. Funded initially in 2013 by VA's Office of Rural Health, the facility enhanced the coordination of care to veterans, particularly those 65 years of age and older, who reside in rural areas of New York's Hudson Valley. Data has shown that the Transition Care Management Program has been successful in reducing emergency room visits and readmissions for the same clinical condition.

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, five credentialing and privileging folders, 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.		
NA	Peer review 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.	• For the five selected licensed independent practitioners' who were trained to perform airway management, there was no evidence of full privileging. • The facility had not completed the conversion from the six-part credentialing and privileging folder to the two-part privileging folder, and there was no written plan for completion of the conversion.	**1.** We recommended that facility managers ensure licensed independent practitioners trained to perform airway management are fully privileged. **2.** We recommended that the facility complete the conversion from the six-part credentialing and privileging folder to the two-part privileging folder.
	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.		
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 Emergency Response Committee meeting minutes reviewed: • The committee did not document the review of each episode. • Code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code.	**3.** We recommended that the Emergency Response Committee document review of each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
NA	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared 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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• 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 the CLC.[b]

At the Montrose campus, we inspected the UCC, primary care clinics, a CLC, the MH unit, and the perimeter of the optometry clinic construction site. At the Castle Point campus, we inspected the UCC, primary care clinics, inpatient medicine, a CLC, and the perimeter of the UCC construction site. Additionally, we reviewed relevant documents and 20 employee training records (16 CLC and 4 housekeeping) 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 IP risk assessment.		
	IP/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.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• A public restroom in the Montrose UCC had an insect infestation problem that was evident on consecutive days despite attempts at corrective action. • Wheelchairs in two of six patient care areas were dirty and/or damaged, including 15 wheelchairs stored as ready for use in the Castle Point UCC.	**4.** We recommended that facility managers ensure public restrooms are free of insects and monitor compliance. **5.** We recommended that the facility clean and/or repair dirty/damaged wheelchairs in patient care areas or remove them from service.
	The facility met IP requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
NA	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
NA	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
NA	The facility met fire safety requirements in critical care.		
NA	The facility met environmental safety requirements in critical care.		
NA	The facility met IP requirements in critical care.		
NA	The facility met medication safety and security requirements in critical care.		
NA	The facility met medical equipment requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
NA	The facility met privacy requirements in critical care.		
NA	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.		
NA	For CLCs with resident animal programs, the facility conducted IP 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 a damaged wheelchair in one of two patient care areas.	See recommendation 5.
	The facility met IP requirements in the CLC.		
	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.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
X	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.	• Walk-off sticky mats were not in place at the construction site adjacent to the Castle Point UCC, and the entrance door to the site was not secured.	**6.** We recommended that facility managers ensure walk-off sticky mats are in place at construction site entrances to minimize dust, ensure site entrances are secured, and monitor compliance.
	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 JC 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 two UCCs, the inpatient medicine unit, and one CLC and for these areas reviewed documentation of 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.		
X	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.	• The facility stocked heparin in concentrations of more than 5,000 units per milliliter on the Castle Point campus inpatient medicine unit, and there was no evidence of approval by the Chief of Pharmacy.	**7.** We recommended that the facility not stock heparin in concentrations of more than 5,000 units per milliliter in patient care areas or document approval by the Chief of Pharmacy to stock in these concentrations.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 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.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	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.	• The facility plan for safe use of automated dispensing machines did not include oversight of overrides.	**8.** We recommended that the facility revise the plan for safe use of automated dispensing machines to include oversight of overrides and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
X	The facility removed medications awaiting destruction or stored them separately from medications available for administration.	• The Castle Point UCC did not have medications awaiting destruction stored separately from those available for administration.	**9.** We recommended that facility managers ensure medications awaiting destruction are stored separately from medications available for administration and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local 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 37 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. 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
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • 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 41 employees (27 randomly selected Level 1 ancillary staff and 14 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.	• Twenty-six Level 1 ancillary staff did not receive level-specific annual MRI safety training.	**10.** 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.		

AIS 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 AIS.[f]

We reviewed relevant documents, the EHRs of six patients who experienced stroke symptoms, and 10 employee training records (five UCC and five inpatient medicine unit), and we conversed with key employees. We also conducted onsite inspections of two UCCs and one inpatient medicine 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
X	The facility's stroke policy addressed all required items.	• Until September 8, 2014, the facility did not have a policy in place that addressed the management of AIS. • The facility's new policy did not address: o Screening for difficulty swallowing o Use of the National Institutes of Health Stroke Scale and tracking of its use	**11.** We recommended that the facility revise the stroke policy to address screening for difficulty swallowing and use of the National Institutes of Health Stroke Scale and tracking of its use and that the facility managers fully implement the revised policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Clinicians did not document evidence of completion of stroke scales for any of the six patients.	**12.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	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.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
	Clinicians provided printed stroke education to patients upon discharge.		
	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or 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	**13.** We recommended that the facility collect and 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.		

EAM

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

We reviewed relevant documents, including competency assessment documentation of five clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and 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	Recommendations
X	The facility had a local EAM policy or had a documented exemption.	• Although the Montrose campus had an exemption and the policy was to call 911, the facility described readiness to perform EAM.	**14.** We recommended that the facility comply with Veterans Health Administration directive requirements for exempted facilities, or if the facility plans intubations during emergency responses, they comply with Veterans Health Administration requirements for non-exempted facilities.
	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.		
X	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	• Facility policy did not address a plan for managing a difficult airway.	**15.** We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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	• None of the five clinicians had evidence of successful demonstration of all required procedural skills on patients.	**16.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.
NA	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		
X	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.	• None of the 30 sampled days had EAM coverage by a provider with completed EAM privileges or a clinician with completed EAM scope of practice during all hours the facility provided patient care.	**17.** We recommended that the facility ensure a provider with completed emergency airway management privileges or a clinician with completed emergency airway management scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.	• The facility did not have video laryngoscopes available for immediate clinician use in either designated location.	**18.** We recommended that facility managers ensure video laryngoscopes are available in all designated locations and monitor compliance.
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy reviewed, which allows for extraordinary circumstances when an individual with demonstrated competency in EAM is not available to perform EAM in the event of an emergency. If this occurs, the facility must conduct a root cause analysis to identify vulnerabilities and initiate appropriate actions to minimize a repeat occurrence. • The facility had an instance when a non-privileged clinician performed an intubation, and there was no documentation of a root cause analysis.	**19.** We recommended that facility managers initiate actions to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and if this does occur, facility managers initiate a root cause analysis.

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans Program, Substance Abuse RRTP, and PTSD RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program, Substance Abuse RRTP, and PTSD RRTP 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.

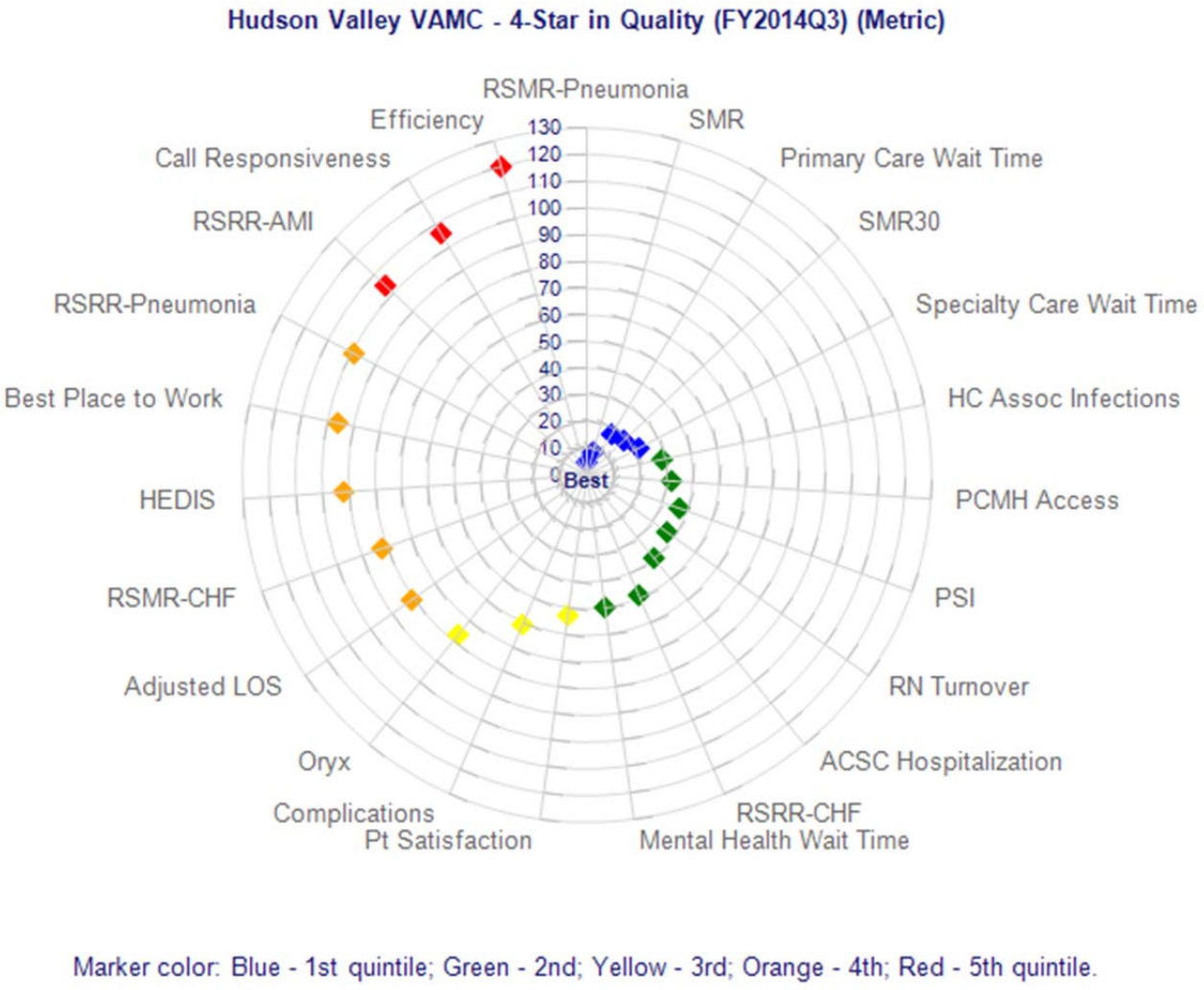
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Montrose/620) FY 2015 through November 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$206.4
Number of:	
• **Unique Patients**	13,607
• **Outpatient Visits**	48,680
• **Unique Employees**[2]	1,102
Type and Number of Operating Beds (as of October):	
• **Hospital**	132
• **CLC**	297
• **MH**	148
Average Daily Census (as of October):	
• **Hospital**	57
• **CLC**	102
• **MH**	94
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	New City/620GA Carmel/620GB Goshen/620GD Port Jervis/620GE Monticello/620GF Poughkeepsie/620GG Eastern Dutchess/620GH
Veterans Integrated Service Network Number	3

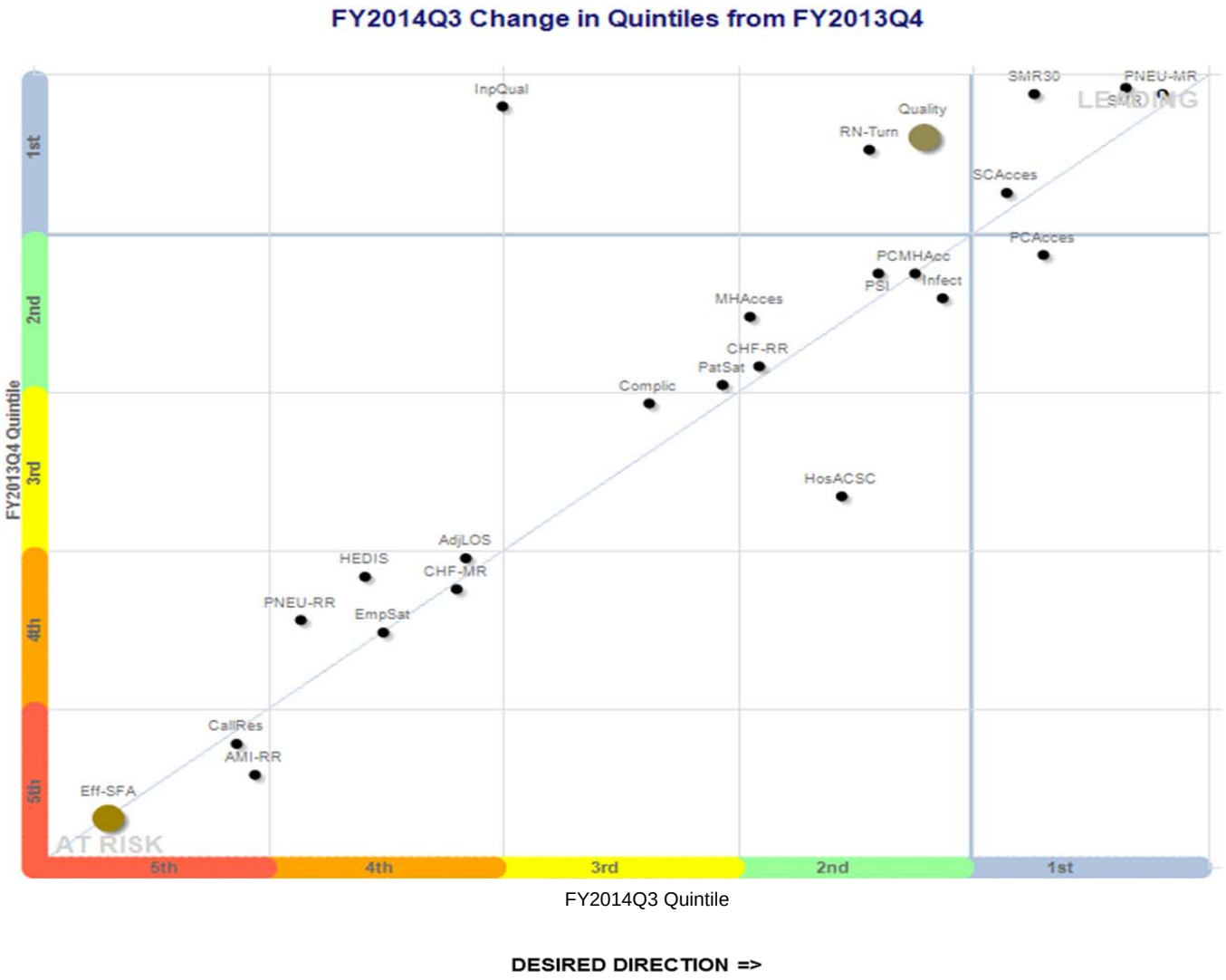
[1] All data is for FY 2015 through November 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 19, 2014

From: Mara Davis, Acting Director, VA NY/NJ Veterans Healthcare Network (10N3)

Subject: **CAP Review of the VA Hudson Valley Health Care System, Montrose, NY**

To: Director, Baltimore Regional Office of Healthcare Inspections (54BA)

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

Attached please find the Combined Assessment Program (CAP) draft response from the VA Hudson Valley Health Care System.

I have reviewed the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality care to Veterans at the VA Hudson Valley Health Care System.

Mara Davis, Acting Director, VA New York/New Jersey Health Care Network

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 19, 2014

From: Margaret B. Caplan, Director, VA Hudson Valley Health Care System (620/00)

Subject: **CAP Review of the VA Hudson Valley Health Care System, Montrose, NY**

To: Director, VA NY/NJ Veterans Healthcare Network (10N3)

I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted on November 3–November 6, 2014.

I have reviewed the findings in the draft report for the VA Hudson Valley Health Care System and concur with the findings and recommendations.

I appreciate the opportunity for this review as an important part of the continuing process to improve the care to our Veterans.

Margaret B. Caplan
Medical Center Director
VA Hudson Valley Health Care System

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 facility managers ensure licensed independent practitioners trained to perform airway management are fully privileged.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: All providers trained in airway management currently have the training clearly noted on the electronic privilege grid. The process for adding emergency airway management to the privilege forms is underway.

Recommendation 2. We recommended that the facility complete the conversion from the six-part credentialing and privileging folder to the two-part privileging folder.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: Credentialing files will be converted to the two-part privileging folders by the Credentialing and Privileging staff.

Recommendation 3. We recommended that the Emergency Response Committee document review of each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: All individual code episode reviews will include documentation of the patient's clinical issues prior to the code that may have contributed to the occurrence of the code. Documentation of discussion will be included in the Emergency Response Committee meeting minutes.

Recommendation 4. We recommended that facility managers ensure public restrooms are free of insects and monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: Pest control was contacted and additional treatment was performed in the restroom areas. The contractor has monitored reported areas weekly with no report of visible insects. An EMS Supervisor continues to check on a daily basis during daily rounds and there is no evidence of insects. The Housekeeping Aid assigned to each area inspects daily to ensure there is no evidence of insects. If insects are found to be present, a work order will be immediately generated and Pest Control will be called for immediate eradication.

Recommendation 5. We recommended that the facility clean and/or repair dirty/damaged wheelchairs in patient care areas or remove them from service.

Concur: Yes

Target date for completion: Delivery of new wheelchairs:
Montrose: December 22, 2014
Castle Point: December 29, 2014

Facility response: All wheelchairs are checked on a daily basis. Project supervisors are assigned to check all areas where wheelchairs are stored and work orders are submitted for any deficiencies in function or cleanliness. If any repairs are needed, the wheelchair is immediately removed from service. Every Wednesday, EMS has a Housekeeping Aid exclusively assigned to clean wheelchairs that need extensive cleaning. Housekeeping Aids and Supervisors inspect all wheelchairs during night rounds inspecting for cleanliness and functionality. Dirty wheelchairs are immediately removed from their location and sent to rolling stock. There have been 12 new wheelchairs per campus ordered to ensure that inventory is not depleted when wheelchairs are removed for cleaning of repair.

Recommendation 6. We recommended that facility managers ensure walk-off sticky mats are in place at construction site entrances to minimize dust, ensure site entrances are secured, and monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: Having walk-off sticky mats in place is already in SOP138-022HV 'Construction Standard Procedures Quality Assurance For Projects,' and all construction sites are checked for compliance on a regular basis by the Project Engineer assigned to that project. This process is audited through weekly rounds by the Construction Safety Committee and reported by exception. The access door cited during the OIG inspection was not a regular construction entrance used for daily operation which is why the mat was

missing. This entrance has since been added as a construction access entrance and the mat will be in place and inspected from this point forward.

Recommendation 7. We recommended that the facility not stock heparin in concentrations of more than 5,000 units per milliliter in patient care areas or document approval by the Chief of Pharmacy to stock in these concentrations.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: Heparin injection was removed from the automated dispensing machine during the OIG CAP survey. The Pharmacy Chief will revise policy 119-12 HV "Medication Inspection for Wards/Units, Residential Units, CLC Homes, Clinics, and Medication Storage Areas" to limit heparin injection concentrations on the patient care units to no more than 5,000 units /ml. Adherence to this revision will be monitored and documented on the Medication Inspection Form for Wards & Clinics and reported quarterly to the Nutrition and Pharmacy/Therapeutics Committee (N&P/T Committee). The Nursing Standard Operating Procedure 118-02HV "Use and Care of Peripherally Inserted Central Catheters (PICCs)" will be revised to address heparin flush use.

Recommendation 8. We recommended that the facility revise the plan for safe use of automated dispensing machines to include oversight of overrides and that facility managers monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: Policy 119-35HV "Automated Dispensing System (Pyxis Medstation System)" will be modified to include the Pharmacy Department's responsibility to review and report total number of override medications, what medications were overridden, and the emergent nature of these occurrences on a monthly basis to N/P & T Committee.

Recommendation 9. We recommended that facility managers ensure medications awaiting destruction are stored separately from medications available for administration and monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: The Pharmacy Department will provide storage bins labeled "return to pharmacy" on all patient care areas to ensure those medications awaiting destructions are separately stored. Adherence to use of these separate bins will be monitored and documented on the Medication Inspection Form for Wards & Clinics and reported quarterly to N/P& T Committee.

Recommendation 10. 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: Yes

Target date for completion: April 30, 2015

Facility response: The MRI Director has identified hospital staff who are required to complete the annual MR Level 1 safety training. The MRI Safety Committee will monitor compliance.

Recommendation 11. We recommended that the facility revise the stroke policy to address screening for difficulty swallowing and use of the National Institutes of Health Stroke Scale and tracking of its use and that the facility managers fully implement the revised policy.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: VAHVHCS Policy: Treatment of Acute Ischemic Stroke will be revised to address screening for difficulty swallowing and the use of the National Institutions of Health Stroke Scale (NIHSS). Clinicians will perform and document a NIHSS Stroke Scale exam and score for all patients who exhibit signs and symptoms of acute ischemic stroke and a dysphagia screening will be performed and documented prior to oral intake. The policy will be fully implemented and use of the NIHSS and dysphagia screen will be tracked by the Hospital Based Care Line Manager.

Recommendation 12. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: Clinicians will perform and document a NIHSS Stroke Scale exam and score for all patients who exhibit signs and symptoms of acute ischemic stroke within the expected time frame. The Hospital Based Care Line Manager will monitor compliance.

Recommendation 13. We recommended that the facility collect and 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: Yes

Target date for completion: April 30, 2015

Facility response: VAHVHCS will collect and report the following data to the Veterans Health Administration: 1) the percent of eligible patients given tissue plasminogen activator; 2) the percent of patients with stroke symptoms who had a stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake. The Hospital Based Care Line Manager will monitor compliance.

Recommendation 14. We recommended that the facility comply with Veterans Health Administration directive requirements for exempted facilities, or if the facility plans intubations during emergency responses, they comply with Veterans Health Administration requirements for non-exempted facilities.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: The Montrose Campus has been granted exempted facility status. The Montrose Campus staff will continue to utilize Basic Life Support (BLS) techniques by trained staff to care for the patient until relieved by the local community 911 Emergency Medical Service (EMS). Code response will be reviewed and monitored with documentation in the ERC Committee meeting minutes.

Recommendation 15. We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: HV Policy 11-45: 'Out of Operating Room Emergency Airway Management' will include a plan to manage a difficult airway with the insertion of a Laryngeal Mask Airway (LMA) or bag valve mask ventilation.

Recommendation 16. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: Clinicians who are designated to perform out of operating room emergency airway management will provide evidence of completed competency assessment that includes all required procedural skills on patients. Training and competency will be monitored by the Hospital Based Care Line and reported to Hospital Based Care Line (HBCL) Committee, Emergency Response Committee and Medical Staff Executive Council.

Recommendation 17. We recommended that the facility ensure a provider with completed emergency airway management privileges or a clinician with completed emergency airway management scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: All providers carrying the Castle Point Campus medical code pager 24/7 will have provided evidence of completed competency assessment. The list of clinicians privileged to perform Out of OR Airway Management will be maintained by the HBCL Office and be evidenced by the Operator Code Pager Report. The ERC will review of the medical code provider assignment and include this in the report to the MSEC. The Hospital Based Care Line Manager will monitor compliance.

Recommendation 18. We recommended that facility managers ensure video laryngoscopes are available in all designated locations and monitor compliance.

Concur: Yes

Target date for completion: April 30, 2015

Facility response: At Castle Point, one video laryngoscope is in the Firefighter's ACLS bag and carried to all medical code events; and one video laryngoscope is in the Urgent Care Center. This equipment will be added to the Code Critique and will be included in the current report presented at the Emergency Response Committee. The Hospital Based Care Line Manager will be responsible for compliance.

Recommendation 19. We recommended that facility managers initiate actions to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and if this does occur, facility managers initiate a root cause analysis.

Concur: Yes

Target date for completion: May 31, 2015

Facility response: The Operator Code Pager Report coverage schedule for the medical code physicians will be used to monitor the assignment of a privileged clinician to perform intubation 24/7 at the Castle Point Campus. A root cause analysis will be initiated by

Quality Management Service in collaboration with the Chief of Staff if it is found that a non-privileged clinician performed an intubation.

Office of Inspector General
Contact and Staff Acknowledgments

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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 JC, 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 JC.

[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 JC, "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 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.