Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-04191-123

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

March 4, 2013

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
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Northport VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
IC	infection control
ICU	intensive care unit
KT	kinesiotherapy
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PT	physical therapy
QM	quality management
TB	tuberculosis
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 December 3, 2012.

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

- Medication Management – Controlled Substances Inspections
- Coordination of Care – Hospice and Palliative Care
- Preventable Pulmonary Embolism

The facility's reported accomplishments were VA Kids Care, the Mobile Unit Podiatry Program, and a Spirit of Planetree Award.

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently report Focused Professional Practice Evaluation results for newly hired licensed independent practitioners to the Medical Executive Committee. Perform continued stay reviews on at least 75 percent of patients in acute beds. Ensure code reviews include screening for clinical issues prior to non-intensive care unit codes that may have contributed to the occurrence of the code. Include all services in electronic health record quality reviews. Ensure clinicians perform and document patient assessments following blood product transfusions.

Environment of Care: Ensure Environment of Care Committee minutes reflect follow-up on actions implemented to address identified problems. Store clean and dirty items separately. Ensure kinesiotherapy clinic staff consistently change linens and clean equipment between patient use. Replace stained privacy curtains in the kinesiotherapy clinic, and routinely inspect and replace curtains as needed. Secure medications in the physical therapy clinic.

Long-Term Home Oxygen Therapy: Ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly and that contracts for oxygen delivery contain educational information on the hazards of smoking while oxygen is in use.

Nurse Staffing: Ensure that all required staff are facility expert panel members and that the facility expert panel reviews the unit-based expert panels' recommendations. Ensure all members of the facility and unit-based expert panels receive the required training.

Construction Safety: Establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities. Ensure that infection control staff conduct contractor tuberculosis risk assessments prior to construction project initiation and that contractor tuberculosis skin test results are documented. Require that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes. Ensure designated employees receive ongoing construction safety training, and monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable Pulmonary Embolism
- Construction Safety

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 2011, FY 2012, and FY 2013 through December 7, 2012, 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 Northport VA Medical Center, Northport, New York,* Report No. 10-00474-14, October 27, 2010).

During this review, we presented crime awareness briefings for 61 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 180 responded. We shared survey 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

VA Kids Care

The facility opened the VA Kids Care Program in April 2012 to improve access to outpatient services for qualified veterans with childcare needs. At no cost to the veteran and with availability 7:00 a.m.–5:30 p.m., the program provides a safe setting for children during the time that their parent(s) receive onsite outpatient care. The facility was one of three VHA facilities selected for a VA childcare pilot project as part of the Caregivers and Veterans Omnibus Health Services Act of 2010.

VA Mobile Unit Podiatry Program

In response to veteran demand and feedback, the facility initiated a mobile unit podiatry program in March 2012 for the Patchogue and Riverhead community based outpatient clinics. Designed to reach veterans living more than 25 miles from the facility, the mobile unit provided 554 podiatry appointments during its first 6 months of operation. This program has mitigated the impact of untoward events from delayed foot care while reducing travel costs and inconvenience for participating veterans.

2012 Spirit of Planetree Award

The facility won a first place 2012 Spirit of Planetree Award for its healing arts small project. With a goal of implementing cultural and environmental changes to promote patient-centered care, the facility used a team approach that supported collaboration, training retreats, and a veteran/family “fair.” Example endeavors that brought about this recognition included initiation of open visitation policies, redesign of palliative care space, and transformation of the CLC into a more home-like environment.

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 complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Nine profiles reviewed: • Results of three FPPEs were not reported to the Medical Executive Committee.
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Ten months of continuing stay data reviewed: • For all 10 months, less than 75 percent of acute inpatients were reviewed.
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	Six months of Code Blue Committee meeting minutes reviewed: • There was no evidence that reviews included screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the code.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of EHR Committee meeting minutes reviewed: • Not all services were included in review of EHR quality.
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	Thirty-two EHRs of patients who received blood products reviewed: • There was no documentation in 6 EHRs (19 percent) that the outcome was assessed.
	CLC minimum data set forms were transmitted to the data center monthly.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

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

3. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the code.

4. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

5. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

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.[2]

We inspected a medical/surgical unit, an ICU, a locked inpatient mental health unit, and a CLC unit. We also inspected the emergency department and the dialysis, women's health, Physical Medicine and Rehabilitation's PT, and CLC's satellite KT clinics. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were tracked to closure.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
X	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of IC Committee meeting minutes reviewed: • Although minutes included identified problems, there was no documentation of follow-up on actions that were implemented to address the problems.
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• In six of the units/areas inspected, clean and dirty items were not stored separately.
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• In the KT clinic, clean and dirty items were not stored separately. • KT clinic staff did not consistently change linen on the exercise platform or clean hand-held weights between patient use. • The KT clinic had stained privacy curtains.
X	Medication safety and security requirements were met.	• The PT clinic had medications stored on an unsecured, dirty table.
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

7. We recommended that processes be strengthened to ensure IC Committee minutes reflect follow-up on actions that were implemented to address identified problems.

8. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

9. We recommended that processes be strengthened to ensure that KT clinic staff consistently change linens and clean equipment between patient use.

10. We recommended that the stained privacy curtains in the KT clinic be replaced and that privacy curtains be routinely inspected and replaced as needed.

11. We recommended that processes be strengthened to ensure that medications in the PT clinic are secured at all times.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of 2 CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 9 patients who were identified as smokers), and we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	• We found no evidence that program activities were reviewed quarterly.
	The facility had established a home respiratory care team.	
X	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	One contract reviewed: • Educational information on the hazards of smoking while oxygen is in use was not incorporated in the contract.
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as smokers received hazards education at least every 6 months after initial delivery.	
NA	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

13. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain educational information on the hazards of smoking while oxygen is in use.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents and 20 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 34 and CLC unit 3 for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
X	The facility expert panel followed the required processes and included all required members.	• The facility expert panel did not include staff nurses, evening and night supervisors, and a Labor Partner representative. • There was no documentation that the facility expert panel reviewed unit 34's or CLC unit 3's unit-based panels' staffing recommendations.
X	Members of the expert panels completed the required training.	• None of the six members of unit 34's panel had completed the required training. • None of the three members of CLC unit 3's panel had completed the required training. • Nine of the 11 members of the facility expert panel had not completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

15. We recommended that the facility expert panel review unit 34's and CLC unit 3's expert panels' recommendations.

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

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[7]

We reviewed relevant documents and nine EHRs of patients with confirmed diagnoses of pulmonary embolism[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Construction Safety

The purpose of this review was to determine whether the facility maintained IC and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the pathology and laboratory renovation project. Additionally, we reviewed relevant documents and 15 training records (5 contractor records and 10 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	There was a multidisciplinary committee to oversee IC and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	• The facility did not have a policy outlining responsibilities of the multidisciplinary committee.
X	IC, preconstruction, interim life safety, and contractor TB risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • Contractor TB risk assessments were not conducted prior to project initiation.
X	There was documentation of results of contractor TB skin testing and of follow-up on any positive results.	• Contractor TB skin test results were not documented.
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
X	IC Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	IC Committee minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to the project.
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
X	Contractors and designated employees received required training.	Employee and contractor training records reviewed: • Eight employee records did not contain evidence of at least 10 hours of construction safety-related training in the past 2 years.
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

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

Recommendations

17. We recommended that the facility establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities.

18. We recommended that processes be strengthened to ensure that IC staff conduct contractor TB risk assessments prior to construction project initiation.

19. We recommended that processes be strengthened to ensure that contractor TB skin test results are documented.

20. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC Committee minutes.

21. We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Facility Profile (Northport/632) FY 2012[b]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (through August 2012)	$288.8
Number of:	
• **Unique Patients**	34,273
• **Outpatient Visits**	392,635
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,544
Type and Number of Operating Beds:	
• **Hospital**	306
• **CLC**	170
• **Domiciliary**	38
Average Daily Census: (through August 2012)	
• **Hospital**	88
• **CLC**	114
• **Domiciliary**	34
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Plainview/632GA Riverhead/632HB Patchoque/632HD
VISN Number	3

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011	FY 2012		
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	59.9	67.3	59.9	62.5	56.7	63.9
VISN	60.4	60.2	56.7	58.6	57.9	58.2
VHA	64.1	63.9	54.5	55.0	54.7	54.3

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	16.0	10.9	12.2	20.6	26.0	21.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[e] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 7, 2013

From: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

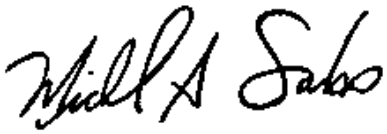
Subject: **CAP Review of the Northport VA Medical Center, Northport, NY**

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

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

I have reviewed the Northport VA Medical Center, Northport NY, and concur with the recommendations.

If you require further information, please contact Pamela Wright, VISN 3 QMO at 718-741-4143.



Michael A. Sabo, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 7, 2013

From: Director, Northport VA Medical Center (632/00)

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

To: Director, VA New York/New Jersey Veterans Healthcare Network (10N3)

1. CAP Review of the Northport VA Medical Center, Northport, NY.

2. Should you have any questions, please do not hesitate to contact Jennifer Newburger, Chief Quality Management at 631-261-4400 extension 2768.

Philip C. Moschitta

PHILIP C. MOSCHITTA

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that results of FPPEs for newly hired licensed independent practitioners are consistently reported to the Medical Executive Committee.

Concur: Yes

Target date for completion: 4/1/13

Facility response: All FPPE results for newly hired licensed independent practitioners will be presented to Clinical Executive Board on a monthly basis.

Recommendation 2. We recommended that processes be strengthened to ensure that continued stay reviews are performed on at least 75 percent of patients in acute beds.

Concur: Yes

Target date for completion: 2/11/2013

Facility response: The Utilization Management program nursing staff will increase from 3 to 4 FTE.

Recommendation 3. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the code.

Concur: Yes

Target date for completion: 4/30/2013

Facility response: The Cardiopulmonary Resuscitation Committee to prepare a review tool to screen for clinical issues prior to non-ICU codes that may have contributed to the occurrence of the code.

Recommendation 4. We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur: Yes

Target date for completion: 4/1/13

Facility response: Medical Records Review Committee is now being restructured. A review process of the EHR will be developed by the services to ensure quality specific measures.

Recommendation 5. We recommended that processes be strengthened to ensure that clinicians perform and document patient assessments following blood product transfusions.

Concur: Yes

Target date for completion: 5/1/13

Facility response: The CPRS nursing note now contains a "no reaction" section for blood transfusions.

Recommendation 6. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to identified deficiencies are tracked to closure.

Concur: Yes

Target date for completion: 1/15/13

Facility response: There has been a process improvement in the EOC minutes. A new grid has been incorporated into the EOC minutes that includes identification of open items, required actions, responsible parties, and completion dates.

Recommendation 7. We recommended that processes be strengthened to ensure IC Committee minutes reflect follow-up on actions that were implemented to address identified problems.

Concur: Yes

Target date for completion: 1/7/13

Facility response: Process for minute taking changed to better reflect action taken on items to completion. At the end of each item, committee members will summarize actions and determine whether the action plan has been completed or will remain open. For those items that remain open, they will be placed under old business on the next committee meeting agenda and will remain as old business until closed.

Recommendation 8. We recommended that processes be strengthened to ensure that clean and dirty items are stored separately.

Concur: Yes

Target date for completion: 3/1/13

Facility response: Supervisors educated on expectations for separation of clean and dirty equipment. All unit managers to clearly designate an area for dirty equipment to be placed for reprocessing. Area supervisors to educate staff on designated areas.

Recommendation 9. We recommended that processes be strengthened to ensure that KT clinic staff consistently change linens and clean equipment between patient use.

Concur: Yes

Target date for completion: 3/1/13

Facility response: KT Supervisor will review the IC policy with KT staff. KT supervisor will ensure compliance with policy. KT supervisor will inspect the area weekly and results reported monthly to ensure compliance.

Recommendation 10. We recommended that the stained privacy curtains in the KT clinic be replaced and that privacy curtains be routinely inspected and replaced as needed.

Concur: Yes

Target date for completion: 2/1/13

Facility response: Two sets of new privacy curtains will be purchased by Environmental Management Service for KT. The privacy curtains in KT will be changed monthly and more frequently as needed. Environmental Management Service will keep a record. Condition of the privacy curtains will be added to IC rounds EOC checklist.

Recommendation 11. We recommended that processes be strengthened to ensure that medications in the PT clinic are secured at all times.

Concur: Yes

Target date for completion: 2/1/13

Facility response: The PT will secure medication in a locked cabinet upon completion of his/her duties in the hydrotherapy/wound care area.

Recommendation 12. We recommended that processes be strengthened to ensure that the Chief of Staff reviews Home Respiratory Care Program activities at least quarterly.

Concur: Yes

Target date for completion: 12/12/12

Facility response: The Chief of Staff has reviewed and signed the Home Respiratory Care Team activities for the 1st Quarter of 2013 following the meeting that was held on 12/12/12. The Chief of Staff will continue to discuss and review the Home Respiratory

Care Team activities each quarter following each successive meeting and sign with his approval.

Recommendation 13. We recommended that processes be strengthened to ensure that contracts for oxygen delivery contain educational information on the hazards of smoking while oxygen is in use.

Concur: Yes

Target date for completion: Awaiting VISN approval

Facility response: The Home Oxygen Contract is a VISN 3, Prosthetic Contract that is being renegotiated at the present time. The VISN Home Oxygen Coordinator has requested that the current contract be amended to be in accordance with VA directives and guidelines.

Recommendation 14. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

Concur: Yes

Target date for completion: 2/15/13

Facility response: Facility expert panel will include staff nurses, evening, and night supervisors, Associate Director Patient Care Services, Associate Chief Nursing Service, Nurse Managers, Human Resource representative, Fiscal Service representative and a Labor Partner representative.

Recommendation 15. We recommended that the facility expert panel review unit 34's and CLC unit 3's expert panels' recommendations.

Concur: Yes

Target date for completion: 2/22/13

Facility response: The facility expert panel will review two inpatient units' (U34 and CLC3) unit-based panels' staffing recommendations by 2/22/13.

Recommendation 16. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur: Yes

Target date for completion: 2/15/13

Facility response: Talent Management System training assigned to all members/staff as identified in recommendation #14.

Recommendation 17. We recommended that the facility establish a policy outlining responsibilities of the multidisciplinary committee that oversees construction and renovation activities.

Concur: Yes

Target date for completion: 4/30/13

Facility response: Final draft of Construction Safety Committee Policy completed. Until adopted, draft policy shall serve as guidance. Policy adoption by April 30, 2013.

Recommendation 18. We recommended that processes be strengthened to ensure that IC staff conduct contractor TB risk assessments prior to construction project initiation.

Concur: Yes

Target date for completion: 4/1/13

Facility response: Revision of CM 001-177 to include TB risk assessment that will be conducted at the time of the preconstruction meeting.

Recommendation 19. We recommended that processes be strengthened to ensure that contractor TB skin test results are documented.

Concur: Yes

Target date for completion: 4/1/13

Facility response: At the time of the OIG-CAP visit, all but two active construction contracts were based on solicitations that were prepared prior to issuance of VHA Directive 2011-036. The remaining two contracts were based on solicitations that were prepared prior to incorporation of the requirements of VHA Directive 2011-036 into the Master Construction Specifications (PG-18-1) issued by VA's Office of Construction and Facilities Management. The requirements of VHA Directive 2011-036 were incorporated into the Master Construction Specifications on 10/1/12. Accordingly, all future construction contracts will include the TB screening requirements. To strengthen the process, the construction management policy will be revised to include a requirement for the contracting officer representative to ensure that all future solicitations include TB screening requirements for contracted construction workers that have been determined to be at risk for transmission of TB to them based upon the TB pre-construction risk assessment.

Recommendation 20. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC Committee minutes.

Concur: Yes

Target date for completion: 3/15/13

Facility response: IC Construction rounds to be conducted as per pending Medical Center Memorandum. Results of construction rounds to be reported monthly to IC.

Recommendation 21. We recommended that processes be strengthened to ensure that designated employees receive ongoing construction safety training and that compliance be monitored.

Concur: Yes

Target date for completion: 5/30/2013

Facility response: Members of Multidisciplinary Inspection team shall receive Occupational Safety and Health Administration Construction Safety Training, as dictated by VHA Directive 2011-036, “Safety and Health during Construction.”

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Donald Braman, RN, Team Leader Jennifer Christensen, DPM Katharine Foster, RN Donna Giroux, RN Douglas Henao, MS, RD Nelson Miranda, LCSW Melanie Oppat, MEd, LDN Joanne Wasko, LCSW Sonia Whig, MS, LDN Cynthia Gallegos, Program Support Assistant Christopher Wagner, Special Agent, Office of Investigations

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Endnotes

[1] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
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- VHA Directive 6300, Records Management, July 10, 2012.
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- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
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- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
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- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
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- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
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- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
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[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
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[6] The references used for this topic were:
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[7] The reference used for this topic was:
- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.

[8] References used for this topic included:
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- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
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