Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

Report No. 06-02245-220 **September 25, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of June 19–23, 2006, the Office of the Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the W.G. (Bill) Hefner Medical Center (the medical center), Salisbury, North Carolina. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 410 employees.

Results of Review

The CAP review focused on six areas. The medical center complied with selected standards in the following three areas:

- Diabetes and Atypical Antipsychotic Medication
- Breast Cancer Management
- Patient Satisfaction

We identified conditions in the Contract Nursing Home (CNH) Program, QM, and Environment of Care that needed management attention. The following recommendations were made:

- Improve oversight of the CNH Program.
- Strengthen selected aspects of the QM program.
- Improve Food and Nutrition Service kitchen ceiling and air diffuser cleanliness.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors concurred with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 12–18 for the full text of the Directors' comments.) We will follow up on planned improvement actions.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is provided at two community based clinics (CBOCs) located in Charlotte and Winston-Salem. The medical center is part of Veterans Integrated Service Network (VISN) 6 and serves a veteran population of about 229,600 in a primary service area that includes 23 counties in the Piedmont region of North Carolina.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 159 hospital beds and 270 long-term care beds and operates several regional referral and treatment programs, including Post-Traumatic Stress Disorder, a Substance Abuse Residential Rehabilitation Treatment Program, and Psychiatric Intensive Care.

Affiliations and Research. The medical center has 13 active research projects with almost $300,000 in funding and collaborates on research with Wake Forest University, the affiliated medical school program. Major areas of research include VA rehabilitation, mobility devices for veterans with visual impairments, and post-deployment mental health issues of returning Operation Enduring Freedom and Operation Iraqi Freedom veterans.

Resources. In fiscal year (FY) 2005, medical care expenditures totaled $187 million. The FY 2006 medical care budget is $200 million. FY 2005 staffing totaled 1,440 full-time equivalent employees (FTE), including 110 physician and 420 nursing FTE.

Workload. In FY 2005, the medical center treated 58,255 unique patients. The medical center provided 33,705 inpatient days of care in the hospital and 54,758 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 2,973 discharges, and the average daily census was 265.8, including nursing home patients. The outpatient workload was 361,622 visits.

Objectives and Scope of the CAP Review

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 facilities focusing on patient care and QM.

- Provide fraud and integrity awareness training 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 the effectiveness of QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review *(Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina*, Report No. 03-02420-06, October 10, 2003*).*

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical and administrative records. The review covered selected aspects of the following programs and activities:

Breast Cancer Management	Environment of Care
Contract Nursing Home Program	Patient Satisfaction
Diabetes and Atypical Antipsychotic Medications	Quality Management

The review covered medical center operations for FY 2005 and FY 2006 through June 23, 2006, and was completed in accordance with OIG standard operating procedures for CAP reviews.

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.

Results of Review

Organizational Strengths

New Technology Improved Patient Care

Medical center management implemented innovative approaches to providing quality patient care by utilizing state of the art technology. Examples include: (a) the purchase of instrumentation to measure troponin[1] at the point of care in the Evaluation Center, allowing for timely evaluation of patients with acute coronary syndrome (ACS); and (b) the implementation of the CareTracker system, which collects charting data through touch-screen devices that encourage NHCU staff to enter all the care they provide. Data reflected improvement in patient outcomes and related performance measures since implementation of these systems.

The medical center's score for the provision of troponin laboratory results within 60 minutes of order time in January 2005 was 50 percent compliance. The Performance Measure target is 89 percent compliance. After implementing the point of care testing, the medical center achieved and maintained 100 percent compliance on this important measure of ACS care. Medical center managers attribute improvement in a Performance Measure related to toileting plans for incontinent patients to implementation of the CareTracker system. As a result of its success at this medical center, VISN 6 has contracted to purchase the CareTracker system for all long term care units in the VISN.

Opportunities for Improvement

Contract Nursing Home Program – Oversight Needed Improvement

We reviewed the CNH Program to assess compliance with national policies regarding program management, the review process for contract renewal, and the monitoring of patients. We evaluated whether there were effective processes in place to more closely monitor the contract nursing facilities where deficiencies had been identified.

The medical center currently has 17 veterans in 11 contract nursing facilities. We selected five contract nursing facilities for review and visited two of them. We interviewed the administrators at these two sites. We conducted 10 patient record reviews and interviewed 4 patients and/or family members. Although VA CNH inspection teams conducted annual inspections, and the contract nursing facility

[1] Troponin is a protein complex which is used as a diagnostic marker for various heart disorders.

administrators felt the VA CNH Program coordinator was accessible and responsive, we found several conditions requiring management attention.

Conditions Needing Improvement. Oversight of the CNH Program needed improvement to ensure that veterans in these facilities received quality care in safe environments. We identified problems in the following Program components:

Ongoing Monitoring and Follow-Up Visits. The VA CNH Program nurse did not perform regular visits to contract nursing facilities to monitor patients. Veterans Health Administration (VHA) Handbook 1143.2 requires that a social worker or registered nurse visit every VA patient under contract in a contract nursing facility at least every 30 days; nurses are expected to visit, at a minimum, every quarter. Although the VA CNH Program coordinator, a social worker, visited the patients monthly, we found no evidence that the VA CNH nurse regularly visited the patients to monitor their medical conditions. Most of the 10 patients in our sample had multiple medical conditions including emphysema, stroke, dysphagia, diabetes, Parkinson's Disease, multiple sclerosis, and chronic renal failure.

On rare occasions, the nurse would visit a patient in response to a request from the contract nursing facility, or when the contract nursing facility reported a sentinel event. She did not conduct follow-up visits to the 10 patients in our sample between October 2003 and June 2006. She told us that she did not have time to make these visits, but reviewed information sent to her by the contract nursing facility staff on each patient. Her infrequent progress note entries indicated that all patients were stable; however, we found progress notes on several patients reflecting recent hospital admissions, significant weight loss, or other clinical changes in condition. She signed one such note on a patient 12 days after his death.

The VA CNH population is aging, frail, and often mentally and/or physically disabled. A registered nurse needs to monitor the medical conditions of these veterans to assure appropriate care in the contract nursing facility and to intervene, when possible, to prevent or minimize hospitalizations.

Oversight of Substandard Nursing Facilities. We found no evidence that VA CNH Program staff increased monitoring of veterans in substandard contract nursing facilities. Four of the 11 contract nursing facilities were currently on the state nursing home "watch list." This list provides consumers with information about nursing homes found to be deficient during their most recent state inspection. The VA CNH Program utilized the "exclusion review" form as part of their initial and annual review. Contract nursing facilities are to be excluded from the program when they exceed the allowable scope, severity, or number of deficiencies, and do not meet minimum threshold standards for quality of care. Several options are available to VA CNH Program managers when a facility does not meet these thresholds, such as termination of the contract, suspension of admissions, more frequent inspections, and increased patient monitoring.

We found that VA CNH Program managers rarely exercised any of these options. All five of the facilities we reviewed did not meet the minimum threshold standards for quality of care, yet all of their contracts were renewed. In some cases, we found that a waiver of the exclusion was requested, but poorly justified. In these cases, we found increased monitoring recommended at the time of contract renewal, but no evidence that it occurred. Increased monitoring of substandard nursing facilities to ensure acceptable standards of care is essential to safeguard the well-being of the veteran residents.

Compliance with Policy. Managers had not established a CNH Oversight Committee, and the VA CNH Program coordinator did not meet with local Ombudsmen as required. VHA Handbook 1143.2 dated June 4, 2004, mandates that a CNH Oversight Committee be established by the Medical Center Director, and that it report to the chief clinical officer. The committee should include multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and medical staff and should meet at least quarterly. Although the medical center had established an inspection team, they had no Oversight Committee to review inspection results, discuss contract renewals, and monitor clinical and billing concerns. The medical center established a committee just prior to our site visit.

VHA policy also requires that each VA CNH inspection team and Oversight Committee establish a working relationship with the appropriate Veterans Benefits Office and the local Ombudsman office to discuss subjects of mutual interest and concern. At a minimum, a yearly meeting should be held with each office. The VA CNH Program coordinator had his first meeting with the Ombudsman just prior to our site visit. The facility CNH Oversight Committee policy, created May 18, 2006, also includes this annual meeting as a Program requirement.

An Oversight Committee provides oversight of CNH Program operations to ensure fiscal accountability, procedural compliance, and quality of clinical care. In addition, the Committee monitors contract nursing facility performance improvement activities and actions taken to correct deficiencies. As the local policy established a system of reporting to ensure ongoing compliance with Oversight Committee requirements, we made no recommendations related to policy compliance.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that: (a) VA CNH Program nurses visit patients in contract facilities no less than quarterly, and as clinically appropriate and (b) VA CNH Program staff increase monitoring of substandard nursing facilities where veterans remain under contract care.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. The CNH Program Coordinator will ensure that the CNH Program nurse visits patients quarterly, and that CNH Program staff increase monitoring of substandard nursing facilities until deficiencies are corrected.

Managers convened an administrative board of investigation (ABI) to review nursing visitation issues. We will follow up on the corrective actions.

Quality Management – Some Processes Needed Improvement

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported and appropriately responded to QM efforts; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. The QM review included a self-assessment of the QM program completed by the quality manager and interviews with senior management staff. With the exception of the following conditions needing improvement, we found that QM staff were supported by senior managers in effectively monitoring patient care activities.

Conditions Needing Improvement. Peer Review, Root Cause Analysis (RCA), and ABI processes needed improvement.

Peer Review Process. Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. A Peer Review Committee (PRC) conducts peer reviews, notifies the Chief of Staff (COS) when the matter being reviewed raises concerns about the possibility of substandard care, and recommends actions needed to protect patients. The PRC should meet quarterly, report at least quarterly to the Executive Committee of the Medical Staff, and track peer review activities.

Peer review tracking had not been completed as required between July 2005 and June 2006. VHA Directive 2004-054, *Peer Review for Quality Management*, and Medical Center Memorandum 11-40, *Peer Review Program*, requires quarterly tracking of peer review activities. Quarterly peer review tracking should include the number of completed reviews, the outcome by level (1, 2, or 3), the number of changes from one level to another during the review process, follow-up on action items, and recommendations that result from completed peer reviews. Without tracking of peer review activities, there is no assurance that trends and/or patterns related to patient treatment outcomes will be identified.

In addition, we found that the PRC had not met since November 2005. The COS told us that he suspended the meetings to protect the confidentiality of the peer review proceedings after the Office of Resolution Management (ORM), in its investigation of an Equal Employment Opportunity (EEO) complaint, requested information from PRC meetings. Peer review proceedings are protected by Title 38, USC Section 5705. When conducted systematically and credibly, peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual

providers' practices. This contributes to organizational performance and optimal patient outcomes.

The COS acknowledged the importance of peer review activities and told us he will resume the meetings, but stated that he will not disclose protected information to ORM. As the peer review process will be resumed, we made no recommendations.

RCA Process. In our review of the individual RCAs conducted between July 2005 and April 2006, we found 4 of 10 did not reflect measurable outcomes and/or did not measure the effectiveness of actions taken. In addition, 7 of 10 did not include all concurrence signatures. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook,* and Medical Center Memorandum 11B-1, *Patient Safety Improvement Program*, require that once an action plan is implemented, there must be a plan for evaluating the effectiveness to assure that changes have the desired effect. Also they require that the RCA is completed as evidenced by the concurrence signatures of all appropriate staff. Without evaluation of outcomes, patient safety effectiveness and improvement cannot be determined. Without signatures by all appropriate staff, there cannot be assurance of concurrence with the RCA findings or the plan for improvement. In our previous CAP report, we also suggested the medical center improve RCA follow-up to determine the effectiveness of actions taken.

ABI Process. In our review of all ABIs involving patient care allegations conducted between July 2005 and April 2006, we found that two of the six did not have all ABI team member signatures, and none of the six included the convening authority (medical center director) certificate of completion. VHA Handbook 0700, *Administrative Investigations*, requires the signature of all ABI team members on the report. If a team member is unable to sign, a statement explaining the reason should be included with the report. The signatures indicate the report accurately reflects the investigation and that each finding of fact, conclusion, and recommendation reflects the view of a majority of the ABI members. Additionally, the Handbook requires the Medical Center Director to certify proper investigation and completion of the ABI in accordance with VHA requirements. The certificate of completion includes an opportunity for the medical center director to modify or comment on the findings of the ABI report, as well as note corrective action taken. The signature of all team members and the certificate of completion certify that the accuracy and completeness of the ABI has been verified.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that: (a) the PRC completes quarterly tracking of peer review activities as required by policy, (b) RCAs have measurable outcomes and effectiveness of actions is evaluated, (c) RCA team members sign completed RCAs, and (d) there are certificates of completion on all ABIs and all members sign the completed reports.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. PRC finding summaries will now include trending of peer review cases with level 2 and 3 findings. Managers implemented an action plan to improve the RCA process which included staff training, VISN level review, and local RCA action tracking. Managers will ensure that ABI and RCA reports have completion certificates and/or signatures prior to closure. We will follow up on the corrective actions.

Environment of Care -– Follow-Up to a Previously Identified Deficiency Was Insufficient

To assess the safety and cleanliness of the medical center, we inspected six patient care areas, selected public areas, and the Food and Nutrition Service (F&NS) kitchen. Overall, we found the medical center to be clean and appropriately maintained. Some minor issues, such as malodorous bathrooms, a loose wall-hung sink, and dusty unoccupied beds were corrected before we left the site. Managers provided us with completed work orders for other identified issues. However, we determined that managers did not follow up on one corrective action taken in response to a patient safety deficiency identified in the 2005 annual workplace evaluation (AWE) report. This condition requires management attention.

Condition Needing Improvement. The 2005 AWE report noted dirty air diffusers (outlets or grilles designed to direct air flow in specific patterns) in the ceiling of the main F&NS kitchen and recommended scheduled monthly cleaning. The main F&NS kitchen ceiling and air diffusers were not clean at the time of our inspection. We found 7 of 29 (24 percent) air diffusers were dirty with dust balls visible in an 8–10 foot radius on the ceiling. The F&NS kitchen prepares food for all patients, and cleanliness is essential to patient health and safety.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that F&NS kitchen ceiling and air diffusers be cleaned regularly and a monitoring system put into place to ensure compliance.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Medical center managers implemented an action plan including regularly scheduled cleaning, annual preventative maintenance, and monitoring to ensure the cleaning is completed as scheduled. We will follow up with the corrective actions.

Other Focused Review Results

Diabetes and Atypical Antipsychotic Medications – Monitoring and Treatment Are Appropriate

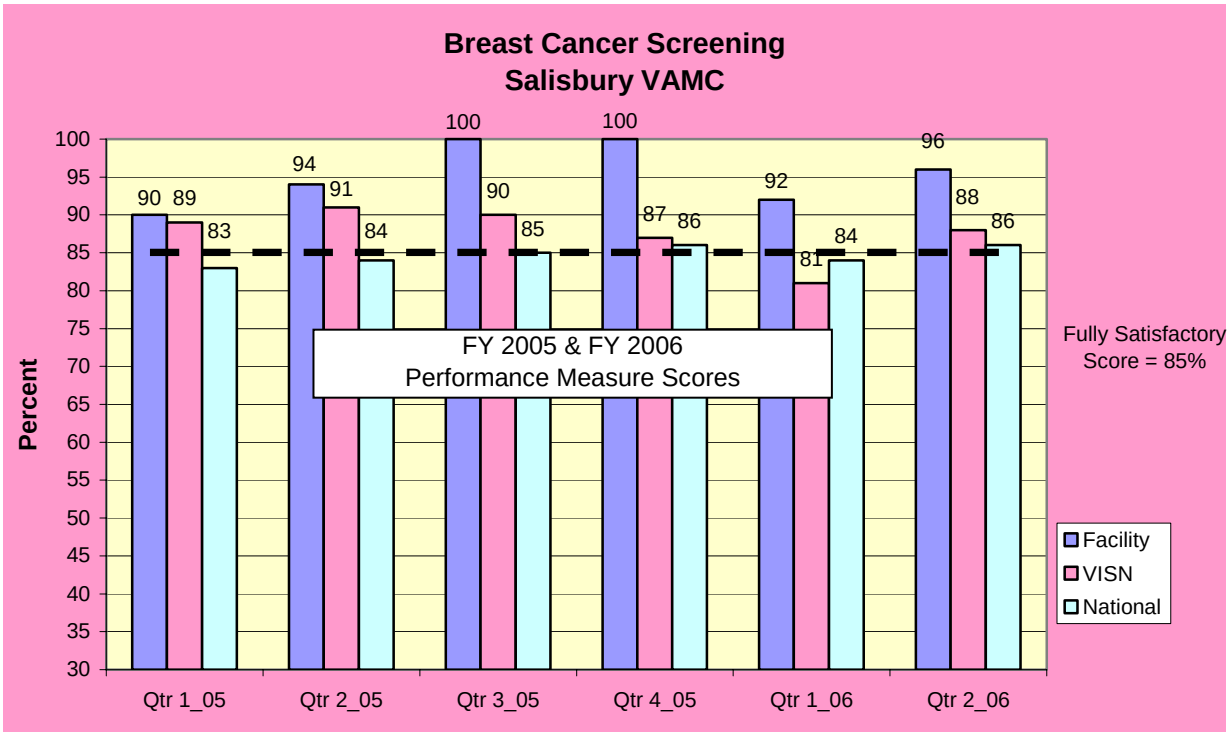
Medical center clinicians performed effective diabetic monitoring and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test. The medical center's value for normal FBG was less than or equal to 115 mg/dl. We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days in FY 2005. Two of the 13 patients were diabetic and appropriately managed. Clinicians obtained FBGs on 10 of the 11 non-diabetic patients.

Appropriate screening also includes assessment of risk factors such as family history of diabetes, overweight, abnormal blood glucose, and hypertension. We found that only 1 of the 11 non-diabetic patients in our sample was questioned about a family history of diabetes. While we were onsite, the medical center developed a clinical reminder on diabetic risk factors for clinicians prescribing atypical antipsychotic medications; therefore, we did not make any recommendations.

Breast Cancer Management – Patients Are Managed Appropriately

The medical center met the VHA performance measure for breast cancer screening, provided timely Surgery and Oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The following table illustrates the medical center's breast cancer screening performance.



All four patients diagnosed with breast cancer during FY 2005 had screening mammograms. Patients received timely biopsies, consultations, and treatments. Clinicians communicated well with patients, keeping them informed of test results and involving them in the treatment planning process. We found patient care was well coordinated from the time of presentation with symptoms (or for screening) to conclusion of treatment.

Patient Satisfaction – Managers Are Addressing Deficiencies

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas including access to care, coordination of care, and courtesy. VHA relies on the analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as very good or excellent. Medical centers are expected to address areas in which they are underperforming. The following graphs show the medical center's (or clinics's) performance in relation to national and VISN performance.

Salisbury Inpatient SHEP Results
Q3 and Q4 FY05

Inpatient - 3Q and 4Q FY05	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.73	78.27	89.40	67.36	65.08	75.37	83.35	73.98	69.52
VISN	82.30	80.30	89.70	69.30	66.70	75.10	83.50	74.90	71.60
Medical Center	85.50	81.90	89.50	66.90	65.60	76.20	86.40	73.00	60.70

Salisbury Outpatient SHEP Results
Q1 FY06

Outpatient - 1Q 2006	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.5	78	95.3	73.1	83.7	76.2	82.6	66.5	82.2	80.7	85.2
VISN	78.9	77.7	95	72	82.8	74.2	83.1	60.7	80.4	81.7	83.7
OUTPATIENT CLINIC Overall	81.7	87.9	93	74	83.7	73.9	91.5	69.6	80.4	81	82.1
SALISBURY	81.2	89	94.1	73.6	82.5	71.1	91.6	64.5	80.2	81.6	81
WINSTON-SALEM	83.7	86.2	90.6	77	87.7	80	*	78.6	81.7	81.1	85.3
CHARLOTTE	77.7	84.6	92.1	65.6	77.6	74.3	91.8	*	76.8	72.8	79.5

** signifies fewer than 30 respondents*

The medical center has a designated SHEP Coordinator who analyzes SHEP results. Several areas were identified for improvement, and corrective action plans were developed to address education and information, emotional support, preferences, transition, overall coordination, and pharmacy. Some examples of the improvement initiatives include: increased use of Krames On-Demand, a commercially available, electronic print-on-demand library of patient education materials; increased use of patient information racks with educational pamphlets; development of Quick Cards patients use to assess their visit to the medical center using actual SHEP questions; creation of maps to assist patients in the location of clinic areas; and development of performance improvement initiatives to lead to improved patient satisfaction.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 7, 2006

From: Director, Mid-Atlantic Healthcare Network (10N6)

Subject: **Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina, Report Number, 2006-02245-HI-0360**

To: Director, Office of Inspector General (53B)

1. The attached subject report is forwarded for your review and further action. I have reviewed the responses and concur with the facility's recommendations.

2. Please contact Donald Moore, Director, VAMC Salisbury at (704) 638-9000 ext. 3344 if you have any questions.

(original signed by:)

Daniel F. Hoffmann, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 7, 2006

From: Director, W.G (Bill) Hefner Medical Center (659/00)

Subject: **Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina, Report Number 2006-02245-HI-0360**

To: Director, Office of Inspector General (53B)

Network Director, VA Mid-Atlantic Health Care Network, VISN 6

1.This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program Review draft report. I concur with all recommendations for improvement identified in the report.

2.The responses and action plans for each recommendation are enclosed.

3. Should you have any questions regarding the comments or implementation plans, please contact me at (704) 638-9000 ext. 3344.

(original signed by:)

DONALD F. MOORE, R.Ph, MBA

Medical Center Director

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:

a. VA CNH Program nurses visit patients in contract facilities no less than quarterly, and as clinically appropriate.

Concur **Target Completion Date:** Completed.

The CNH Coordinator has been assigned responsibility for ensuring that the CNH Program Nurse visits patients in contract facilities no less than quarterly. The CNH Program Coordinator has also been assigned responsibility to ensure that a CNH Program Nurse makes additional visits for any clinical trigger, as outlined in Section 9 of VHA Handbook 1143.2, dated June, 2004. The CNH Program Nurse has visited all Salisbury VA patients in CNHs in late June and early July, 2006, with the exception of one facility which had already been visited by the Durham VA CNH Program Nurse during this quarter.

An Administrative Board of Investigation was initiated to investigate prior performance deficiencies of the CNH Program Nurse. Findings and recommendations are due to the Medical Center Director on August 25, 2006.

b. VA CNH Program staff increase monitoring of substandard nursing facilities where veterans remain under contract.

Concur **Target Completion Date:** Completed.

All veterans in substandard contract nursing facilities will be monitored at an increased frequency until all deficiencies have been corrected. The CNH Program Coordinator has established an electronic tickler file to ensure the timely completion of the increased monitoring. The five substandard facilities were all visited by the CNH Program Nurse in early July, 2006. Those facilities that remain rated as substandard by state, will continue to be monitored at the increased frequency of a monthly CNH Program Nurse visit, in addition to a monthly CNH Social Worker visit, until the deficiencies have been corrected. This increased monitoring will be reported to the Contract Nursing Home Oversight Committee, with minutes to the Clinical Executive Board.

Recommended Improvement Action(s) 2. The VISN director should ensure that the Medical Center Director requires that:

a. The PRC completes quarterly tracking of peer review activities as required by policy.

Concur **Target Completion Date:** Completed.

A summary of Peer Review Committee findings, including tracking the number of reviews, level of outcomes, changes in levels, action item follow-ups, and recommendations will continue to be presented to the Clinical Executive Board, but now includes trending of the types of cases that resulted in level 2 and 3 findings. Such a comprehensive summary of all the FY05 Peer Review Committee findings was presented at the July 26, 2006 Clinical Executive Board meeting.

b. RCAs have measurable outcomes and effectiveness of actions is evaluated.

Concur **Target Completion Date:** Completed.

In an effort to improve staff abilities related to drilling down to the root causes of events, strengthening actions and ensuring that actions are measurable, training has been scheduled by the VISN 6 Patient Safety Officer for all VISN 6 Patient Safety Managers and their primary back-ups in September 2006. The agenda for this training will include:

- Developing More Meaningful Root Cause/Contributing Factor Statements

- Writing Stronger Action Plans

- Improving measurements (Increasing Objective Measurement)

In addition, there is now a VISN 6 plan in place to review action plans and measurements of selected Root Cause Analyses within the network Patient Safety peer group. During monthly VISN Patient Safety conference calls, each facility Patient Safety Manager has been encouraged to share recently completed RCAs. The goal of this process is to share experiences, information, and ideas in an effort to strengthen actions and ensure measurability. The VISN Patient Safety Officer is also available to review root cause statements and action plans as requested by the facility Patient Safety Manager.

Within the Salisbury VAMC, actions and measurements are reviewed with the individuals who will be responsible to implement the actions and make the measurements during the conduct of the RCA. The status of measurements is tracked on a tracking sheet maintained in the Office of Performance and Quality. Responsible individuals are reminded of actions and measurements due at intervals prior to due dates by the Patient Safety Manager. The tracking record is updated monthly in the Office of Performance and Quality and any overdue actions or measures are forwarded to the appropriate service line for intervention. This information is reviewed at the Clinical Executive Board (CEB).

c. RCA team members sign completed RCAs.

Concur **Target Completion Date:** Completed.

The team leader of each root cause analysis (RCA) has the responsibility to obtain all signatures of appropriate staff. The team leader will be instructed and reminded by the Patient Safety Manager to obtain the signatures prior to the discussion with the Medical Center Director.

d. There are certificates of completion on all ABIs and all members sign the completed reports.

Concur **Target Completion Date:** Completed.

The following statement has been added to the Recommendation Sheet signed by the Director after the review, presentation and discussion of each Administrative Board of Investigation:

"I have conducted a review of the attached report of investigation dated (Report date) into (Subject from Charge Letter) in accordance with VA Handbook 0700. This investigation was convened by my charge letter of _____, 2006.

I certify that this report has been reviewed for compliance with VA Directive and Handbook 0700, and the subject of the report has been properly investigated."

_____ _____

Convening Authority Date

In addition, the Chair of each ABOI will be instructed that all signatures must be obtained prior to the presentation and discussion of the investigation. No investigations will be signed as completed until all signatures are obtained

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that the F&NS kitchen ceiling and air diffusers are cleaned regularly and a monitoring system put into place to ensure compliance.

Concur **Target Completion Date:** Completed.

The following action plan has been put in place to ensure that the kitchen diffusers stay clean and free of dirt:

a. Nutrition and Food Service has included the diffusers on their regular cleaning schedule. The surface of the diffusers and surrounding ceiling will be cleaned and dusted monthly.

b. Facilities Management has included the diffusers in the preventive maintenance program for the Utility Shop. These diffusers and associated duct work will be cleaned annually. This will be accomplished by writing a service to a contractor who specializes in duct/diffuser cleaning.

c. Nutrition and Food Service and Facilities Management will jointly monitor the diffusers to ensure that the cleaning is completed as scheduled.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Susan Zarter, Healthcare Inspections Team Leader Victoria Coates Bertha Clarke Steve Fulmer Toni Woodard

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
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Director, VA Mid-Atlantic Healthcare Network (10N6)
Director, W. G. (Bill) Hefner VA Medical Center (659/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Elizabeth Dole, Richard Burr
U.S. House of Representatives: Howard Coble, Melvin L. Watt

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