Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Follow-Up Evaluation of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

Report No. 07-01796-181 **August 2, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Contents

Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, conducted a review to follow up on two previous reports: (1) the Office of the Medical Inspector (OMI) report, *Review of the Delivery of Surgical Services*, June 9, 2005, and (2) the OIG report, *Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina* (Report No. 06-02245-220, September 25, 2006). The purpose was to determine whether OMI's and OIG's recommendations were implemented; we also determined whether adverse conditions identified in those reports were resolved or improved. We also evaluated a concern regarding the adequacy of communication between OMI and OIG and reviewed an April 2007 hotline complaint related to quality of care. We conducted an environment of care (EOC) inspection of patient care areas, and we evaluated the medical center's performance in relation to Veterans Health Administration performance measures and patient satisfaction goals.

We visited the Salisbury VA Medical Center (the medical center) during the week of April 9, 2007. We found that medical center managers implemented corrective actions that resolved or improved the deficiencies cited in the 2005 OMI report and the 2006 OIG report. We confirmed that communication processes between OMI and OIG needed improvement. We did not substantiate the recent hotline allegation that a patient received poor quality of care at the medical center.

During the course of this review, however, we found two EOC deficiencies in areas that were not previously inspected by the OIG or OMI and required management attention. We found that private patient bathrooms on the locked mental health units had exposed pipes that could pose a safety risk to patients. In addition, we found that tunnels connecting buildings on the campus did not have emergency call systems accessible to patients or visitors.

We determined that the medical center's performance measure scores for the 1st quarter 2007 met or exceeded established goals in virtually all areas measured. The most recent Survey of Healthcare Experiences of Patients results showed that patients were generally satisfied, although improvements were still needed in some inpatient areas.

To enhance patient safety, we made the following recommendations:

- Ensure that lavatory waste and supply pipes on the mental health units are covered.
- Ensure that an emergency alert system in long connecting tunnels is accessible to patients, visitors, and staff.

Introduction

Purpose

At the request of Chairman Bob Filner of the House of Representatives Committee on Veterans' Affairs (HVAC) and Chairman Harry E. Mitchell of the HVAC Subcommittee on Oversight and Investigations, the VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted a review to follow-up on the Office of the Medical Inspector (OMI) report, *Review of the Delivery of Surgical Services*, June 9, 2005, and to follow-up on the OIG report, *Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina*, (Report No. 06-02245-220, September 25, 2006). The purpose was to determine whether the OMI report and the OIG Combined Assessment Program (CAP) recommendations had been implemented; in addition, we planned to determine whether adverse conditions identified in those reports were resolved or improved. We evaluated a concern about inadequate communication between OMI and OIG, and we reviewed an April 2007 hotline allegation related to quality of care. We conducted an environment of care (EOC) inspection of patient care areas, and we also evaluated the medical center's performance in relation to Veterans Health Administration (VHA) performance measures and patient satisfaction goals.

Background

The medical center is a tertiary care facility that provides medical, surgical, rehabilitative, and nursing home care to veterans in a primary service area that includes 23 counties in the Piedmont region of North Carolina. The medical center has 159 hospital beds and 270 long-term care beds, and it operates community based outpatient clinics in Charlotte and Winston-Salem.

In March 2007, articles appearing in the public media referenced the 2005 OMI report and the 2006 OIG report. The articles specifically noted that OMI found surgical care at the medical center to be "marginal at best and in some cases, substandard," and OIG found that a VA nurse reported inaccurate clinical information in the medical records of veterans in contract community nursing homes (CNHs).

Chairman Filner, along with North Carolina Representatives Mel Watt, Howard Coble, and Robin Hayes, requested that OIG evaluate whether the medical center adequately addressed the previous OMI and OIG reports' recommendations and determine whether the previously identified conditions were improved or resolved.

In addition, Chairman Filner stated his concern that the process to ensure communication and accountability between OMI and OIG was deficient.

2005 OMI Review. In August 2004, an anonymous complainant reported to OIG's Hotline division that over the previous 2-year period, 12 surgical patients died unexpectedly at the medical center. OIG, an independent oversight organization, referred the case to OMI, VHA's internal review unit. OIG has oversight responsibility for OMI activities and, in an effort to evaluate complaints in a timely manner, occasionally requests that OMI undertake medical reviews. The results of these OMI inspections are reviewed by OIG.

The complainant provided specific information on only one case, that of a patient who was admitted for a toe amputation but died after improper post-operative care. OMI was later contacted by the family of a patient who died at the medical center in 2003. While this was a medical patient, not a surgical patient, the OMI accepted this case as well. In March 2005, OMI visited the medical center to review the care of these two patients and assess the adequacy of surgical services in general. OMI determined that the surgical patient received poor post-operative care following a toe amputation and the medical patient's care did not meet standards of care. OMI also found multiple deficiencies related to staffing, documentation, communication, and performance improvement (PI) in Surgical Service. OMI recommended a number of changes to improve the quality of care for surgical patients.

2005 National Director of Surgery Review. In May 2005, VHA's National Director of Surgery visited the medical center. Since the complainant did not provide the names of other surgical patients who allegedly died unexpectedly, the Director of Surgery reviewed all surgical deaths that occurred in the previous 2 years. His review did not substantiate the allegations. He agreed with OMI that in the surgical index case, the patient received poor post-operative care. However, he did not identify quality of care issues for the other 16 surgical patients who died in fiscal years 2002, 2003, or 2004.[1]

2006 OIG CAP Review. In June 2006, OIG conducted a routine CAP review and found deficiencies in CNH program oversight, quality management (QM), and EOC, and made recommendations for improvements. OIG did not specifically review Surgical Service issues or follow up on OMI's recommendations from their 2005 report. The 2006 OIG CAP report can be accessed at http://www.va.gov/oig/cap/VAOIG-06-02245-220.pdf

2007 Hotline Case. In April 2007, OIG's Hotline division received a complaint alleging poor quality of care. In this case, the complainant reported that her father did not receive radiology examinations which would have saved his life.

In response to the Congressional request and the new hotline allegation of poor care, OIG conducted a follow up visit to the medical center the week of April 9–13, 2007.

[1] The deaths were identified through National Surgical Quality Improvement Program (NSQIP) reports.

Scope and Methodology

Prior to our visit, we reviewed the 2005 OMI report, the report from VHA's National Director of Surgery, and the 2006 OIG report. We interviewed OMI employees who conducted a follow-up site visit in March 2007 to evaluate the status of surgical issues at the medical center. We also interviewed medical center managers and employees, reviewed QM and administrative records, evaluated medical records of selected patients, and conducted an EOC inspection. In addition, we assessed the medical center's achievement of VHA performance measure and patient satisfaction goals. We also reviewed relevant articles which had appeared in the public media.

This review was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Evaluation Results

Overall, we found that conditions identified in the 2005 OMI and 2006 OIG reports were resolved or improved. QM and other performance measures indicated that the medical center delivered appropriate patient care and patients were generally satisfied with the care they receive. The medical center is accredited by The Joint Commission[2] for the triennial cycle ending in August 2008.

Follow-Up to 2005 OMI Recommendations

Medical center managers implemented corrective actions that resolved or improved the deficiencies cited in the 2005 OMI report regarding surgical services. See Appendix A on pages 9–15 for the 2005 OMI report recommendations, actions taken, and current status.

We did not review individual surgical cases; rather, we evaluated the medical center's systems and processes designed to ensure that the quality of surgical services and patient safety practices met community standards of care.

Notably, Surgical Service initiated an active PI program, with the following results:

- In April 2006, the average delay to start the first surgical case of the day was 55 minutes; in February 2007, the average delay was 15 minutes.
- The medical center met or exceeded the performance measure target scores (1st quarter 2007) for timely administration of antibiotics, use of appropriate antibiotics, surgical site hair removal, and normothermia (normal body temperature). The medical center scored an 86 (target 87) for the timely discontinuation of antibiotics after surgery.
- According to NSQIP, a repository for surgical complication and outcome data, since 2004 the medical center's surgical morbidity and mortality rate ranked substantially lower than the national mean, as follows:
    - In fiscal years (FYs) 2004–2006, the mortality observed to expected (O/E) ratio was 0.86; the national mean O/E was 1.00.
    - In FYs 2004–2006, the morbidity O/E was 0.46; the national mean O/E was 1.00.

Follow-Up to 2006 OIG Recommendations

Medical center managers implemented corrective actions that resolved or improved the deficiencies cited in the 2006 CAP report. See Appendix B on pages 16–19 for the OIG CAP report recommendations, actions taken, and current status.

[2] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations."

OMI-OIG Communication and Accountability

We validated Chairman Filner's concern that the process to ensure communication and accountability between OMI and OIG was deficient. Representatives from OMI and OIG have regular meetings in Washington, DC, to discuss OMI cases. However, the Atlanta OIG field office, which has regional oversight jurisdiction over the medical center, was not aware of OMI activities and did not have access to OMI reports related to the medical center. In April 2007, OHI managers posted a spreadsheet of OMI activities on a secure network that is accessible to appropriate field office personnel. The spreadsheet is updated after all OMI-OIG meetings.

As OIG has oversight responsibility for OMI activities, all published OMI reports will also be available to all OIG field offices for review. Should follow-up of OMI findings and recommendations be warranted, appropriate OIG offices will include these elements in their project work plans and published OIG reports.

Case Review – Delay in Care

In April 2007, OIG's Hotline division received a complaint from the daughter of a deceased veteran alleging that her father received inadequate care at the medical center that lead to his demise. The complainant alleged that her father frequently visited the medical center requesting radiology examinations due to health concerns. The patient was allegedly told that his problems were related to chronic obstructive pulmonary disease (COPD) and age-related issues, and the examinations were not ordered. After many pleas, the patient underwent a computerized tomography scan (CT) which revealed "spots in his head"; her father died soon after this diagnostic test. The complainant alleged that if the medical center staff had heeded the patient's pleas for diagnostic testing and medical care, he would not have died.

Case Summary. The patient was a 70-year-old male with a past medical history of severe COPD, depressive neurosis, panic disorder, congestive heart failure, and dementia. The patient had been treated at the medical center since 1997. The patient had been exposed to asbestos in the Navy; he was also a heavy smoker by social history, smoking two packs of cigarettes per day for the last 50 years.

On February 12, 2003, a CT of the brain revealed what was suspected to be metastatic lesions from a primary cancer (site unknown). The patient elected not to complete further diagnostic testing or treatment and was transferred to hospice care after his other medical conditions stabilized. The daughter was with her father at the time of his death on April 9, 2003. The patient's discharge summary indicates respiratory failure secondary to probable lung cancer as the cause of death. The daughter declined an autopsy.

We reviewed the patient's medical record from 1997-2003 and found no evidence that the patient had requested diagnostic x-ray or CT scans at any time. A 1997 CT scan of the chest revealed a lung nodule which clinicians monitored; in January 2003, a CT showed the nodule to be unchanged from previous reports. Progress notes reflect that clinicians closely monitored the patient's pulmonary condition and addressed his multiple medical problems during primary care clinic appointments, emergency room visits, and hospital admissions. There is no evidence in the medical record to indicate any delay in testing was a contributing cause of death. We found that clinical staff provided appropriate care to the patient.

Environment of Care

The medical center is comprised of 35 buildings located on 91 acres and was built in 1952. Despite the size of the campus, multiple buildings, and old construction, the facility was generally very clean and well maintained. However, we identified two patient safety issues requiring management attention.

Lavatory pipes in patient bathrooms on the locked mental health units were exposed, thus presenting a safety hazard to high-risk patients. The National Association of Psychiatric Health Systems guidance booklet states, "All lavatory waste and supply piping must be enclosed and should not be accessible to patients."

We also found that many of the medical center's buildings were connected by long tunnels or enclosed passageways. While phones were located in the tunnels, they were only accessible to staff with appropriate keys. Patients and visitors had no way to call for help in the event of an emergency.

Performance Measures and Patient Satisfaction

VHA performance measures demonstrate a medical facility's compliance with clinical practice guidelines that are designed to achieve high quality health outcomes reliably and efficiently. Performance measures set national benchmarks for the quality of preventive and therapeutic healthcare services in areas such as ischemic heart disease, diabetes, and COPD. VHA uses comparative data from within the organization and from the private sector to hold managers accountable for less than optimal performance, and to demonstrate best practices in health care delivery.

Overall, the medical center's performance measure scores met or exceeded standards. In the 1st quarter 2007, the medical center had only a few outliers, primarily related to access to specialists. In each case, a "champion" for that measure submitted an action plan to improve scores. The tracking of performance measure scores, corrective actions, and follow-up was excellent.

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.[3] VHA relies on the survey data to improve the quality of care delivered to patients. In general, the medical center's outpatient SHEP scores met or exceeded goals in the 1st quarter 2007. The medical center was underperforming in the area of "specialist care," possibly because many specialties are not available at the medical center, and patients must be referred to other VA or private facilities for care. At the time of our visit, the medical center was recruiting for an orthopedist, cardiologist, and gastroenterologist. For the 3rd and 4th quarters 2006 (the most recent data available), the medical center's inpatient scores did not meet established goals in five areas. We found that the medical center's SHEP program was not fully developed at the time of our visit, and managers had only recently established a system to review and disseminate SHEP data for follow-up and improvement actions.

Conclusion

Medical center managers implemented corrective actions, and those conditions identified in the 2005 OMI and the 2006 OIG reports have resolved or improved. The systems and processes to ensure quality surgical services and patient safety practices have improved, and surgical PI activities reflected substantial compliance with VHA performance measures. Medical center managers took appropriate action to ensure that CNH patients received nursing visits in accordance with policy and that VA CNH Program staff increased the oversight of underperforming CNHs.

We confirmed that while the OMI and OIG had regular meetings, the OIG field office responsible for the Salisbury, NC, area was not aware of OMI activities related to the medical center's surgery program. Actions have been initiated to ensure that OIG field offices have access to and follow up on OMI reports.

We did not substantiate a complaint of delayed care; rather, we determined that the patient received appropriate evaluation and treatment.

During the course of our review, we noted that patient bathrooms on the locked mental health units had exposed lavatory waste and supply pipes. In addition, patients and visitors did not have access to emergency call systems in long tunnels that connected many of the medical center's buildings. Both of these conditions presented patient safety risks and required management attention.

As evidenced by performance measure and patient satisfaction scores, it appears that the medical center delivers appropriate patient care and that patients are generally satisfied with the care they receive.

[3] vaww.oqp.med.va.gov It should be noted that information referenced from this website is a VA intranet site not available outside the VA system.

Recommendations

To enhance patient safety, we made the following recommendations:

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires that lavatory waste and supply pipes on the mental health units are covered.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director implements an emergency alert system in long connecting tunnels that is accessible to patients, visitors, and staff.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. Actions have been initiated to retrofit the mental health units' bathrooms with protective coverings so that pipes are not accessible. The Mental Health Service has developed an interim staffing plan to ensure appropriate supervision of high-risk patients pending completion of the structural changes. In addition, emergency call boxes have been installed in connecting tunnels. See pages 20–22 for the Directors' comments. We will follow up until the planned actions are completed.

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

Appendix A

Follow-Up Evaluation of Clinical Issues
Salisbury, North Carolina

OMI REPORT, *Review of the Delivery of Surgical Services*, June 9, 2005

The following matrix shows the primary issues and recommendations as identified in the **2005 OMI** report and the current status of those conditions and recommendations.

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
The peer review committee (PRC) process is not clearly defined.	Policy should define the roles and responsibility of the PRC members and the peer review process.	**Resolved**	PRC policy MCM 11-40, *Peer Review Program*, dated February 4, 2005, describes the peer review process and defines roles and responsibilities of PRC members.
Root cause analyses (RCAs) did not identify all root causes of an event.	Identify all root causes in the RCA process.	**Resolved**	The National Center for Patient Safety (NCPS) reviews every RCA and provides feedback as appropriate. RCA teams receive just-in-time training to identify root causes for each event. The NCPS conducted an on-site inspection on May 16, 2006, and assessed 45 standards. The standards encompassed leadership/ support, staffing, resources, RCA activities, the Patient Safety Reporting System, general program functions, and alerts and advisories. Only one standard out of the 45 was not met. This involved

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
			clerical support for entering patient safety reports into the Patient Safety Information System database. Three staff members attended the NCPS Patient Safety 101 training in the Spring of 2006. The Patient Safety Officer (PSO) participated in VISN 6 RCA training with other PSOs in September 2006. The PSO also attended a national conference in 2007.
Progress notes for a patient were copied and pasted with the same content on successive days in the computerized patient record system (CPRS).	All progress notes should be in compliance with policy and reflect current clinical information for the patient on the day the note is entered.	**Resolved**	MCM 136-5, *Confidentiality and Release of Medical Administrative Information*, dated July 23, 2004, addresses the copy and paste function. An addendum was made to the Medical Staff Bylaws and Rules prohibiting the use of copying and pasting. All providers signed statements acknowledging that they would not copy and paste. The Medical Record Committee (MRC) monitors progress notes for copying and pasting, and the results are presented at the MRC meetings.

Appendix A

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
Patients and their families are not informed of adverse events per VHA Handbook 1050.1 requirements.	Develop and implement a disclosure policy.	**Resolved**	MCM 11-44, *Disclosure of Adverse Events to Patients*, dated March 22, 2006, was developed. The Chief of Staff called the families of the two original cases the OMI identified to disclose the treatment outcomes. Managers provided us with examples of patient progress notes documenting disclosure.
Family members did not know the results of autopsies.	Autopsy results need to be communicated to family members by a designated member of the healthcare team.	**Resolved**	An addendum was made to the medical staff by-laws stating that attending physicians are required to offer an autopsy to the families of patients who have died at the medical center. The attending physician must advise families, or other appropriate individuals, of the results of autopsies in a timely manner. Three autopsies were performed in 2006, and documentation shows that families were informed of the results. No autopsies had been performed as of April 13, 2007.

Appendix A

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
Performance improvement is lacking in Surgery Service; Morbidity & Mortality (M&M) conferences did not take place.	Surgery Service should conduct M&M conferences and other PI activities.	**Resolved**	M&M occurs at least monthly, and recently, has occurred weekly. The minutes reflect documentation of discussions. A nurse is assigned to surgery to monitor PI processes. All operating room (OR) staff are involved in the PI process. Surgical staff completed the Medical Team Training, a Patient Safety initiative on communication.
Medications in the OR were unsecured.	Secure all medications as required.	**Resolved**	An Omnicell, a dispensing cabinet that controls and secures access to medications, was placed in the post-anesthesia care unit (PACU). One rolling cart with two locks was also provided. All medication refrigerators have locks. All medications are secured in a locked medication cabinet in the new minor procedure room.
Surgery Service does not notify the PSO of unexpected events.	Surgery staff should participate in the patient safety program for the medical center.	**Resolved**	An anonymous electronic Patient Incident Reporting (PIR) system is in place.

Appendix A

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
			Surgical staff participate on RCA teams. The NSQIP nurse works closely with surgery and identifies any unexpected events during or following surgery.
The PACU is staffed by cross trained OR nurses and lacks a regularly assigned nursing staff.	Assign permanent nursing staff to the PACU.	**Resolved**	A permanent staff of nine nurses are assigned to the PACU. Managers initiated an on-call schedule for the PACU nurses in January 2007 providing 24/7 coverage.
Nurses on the surgical inpatient unit did not have competencies reviewed and verified annually.	Ensure that surgical nurses have competencies verified annually.	**Resolved**	Twenty-four of 24 nurse competency folders we reviewed were current or less than 30 days overdue for review.
Committee meeting minutes did not identify action items for follow up.	Committee minutes need to reflect discussion, action items and the individuals responsible for follow-up, and action item completion/outcomes.	**Resolved**	The format for committee minutes was changed to reflect discussion/findings/conclusions, recommendations/actions, responsibility, and target dates. A template of the new minutes format was available to staff on a desktop icon. Our review of committee minutes

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
			showed staff using the new format.
Critically ill patients are not transferred in a timely manner during non-administrative hours.	All staff should be educated on the process for transferring patients.	**Resolved**	Managers established a standardized approach to hand-off communication using an ISBAR form: Information, Situation, Background, Assessment, and Recommendations. Forms are maintained in a folder accessible to each hospitalist, Medical Officer of the Day (MOD), and fee basis physician. Surgeons now cover their own patients during non-administrative hours, and the nurses call them directly. The MOD provides emergency care for all patients in the medical center and works with the Administrative Officer of the Day (AOD) when a patient's transfer is necessary based on clinical judgment. This is outlined in Attachment A of the MCM 11A-6, *Medical Officer of the Day*, dated October 15, 2004.
Medical center policy does not address physician coverage during non-administrative hours.	Develop a policy defining physician coverage during non-administrative hours.	**Resolved**	MCM, 11A-6, *Medical Officer of the Day*, outlines the MOD's responsibilities for providing medical care to patients during non-administrative hours.

Appendix A

Report Issues	2005 OMI Report Recommendations	Status as of March 30 , 2007	Action(s) Taken
			Surgeons cover their own patients and contract physicians cover the medical patients. There is an on-call list for the hospitalists, cardiologists, and so forth, so the contract physicians know whom to contact if needed. E-mail regarding coverage and call schedules is sent to all units, and the numbers are posted in the nursing station. The AOD has copies of call schedules.
Physicians performing procedures with conscious sedation (CS) did not have the appropriate privileges.	Physicians need to have privileges to perform CS.	**Resolved**	The Credentialing and Privileging folders of the nine physicians who use CS included the appropriate documentation of privileges.

Appendix B

Follow-Up Evaluation of Clinical Issues
Salisbury, North Carolina

OIG REPORT, *Combined Assessment Program Review of the VA Medical Center, Salisbury, NC,* September 25, 2006

The following matrix shows the primary issues and recommendations as identified in the **2006 OIG** CAP report and the current status of those conditions and recommendations.

Report Issues	2006 OIG CAP Report Recommendations	Status as of April 9, 2007	Action(s) Taken
The VA CNH Program nurse did not perform regular visits to monitor patients in CNHs. (This issue also involved the nurse reporting inaccurate clinical information in CNH patients' records.)	Ensure VA CNH Program nurses visit patients in contract facilities at least quarterly and as clinically appropriate.	**Resolved**	Appropriate action was taken against the nurse who did not visit the patients, as well as against her supervisors. A half-time registered nurse (RN) position has been added. Nurse visitation is occurring at least every 60 days, and every 30 days in homes in need of additional monitoring or those on the Watch List. Patients are seen more often if clinically indicated. A nursing clinical supervisor is responsible for direct supervision of the RN until a new CNH Program Coordinator is appointed.

Report Issues	2006 OIG CAP Report Recommendations	Status as of April 9, 2007	Action(s) Taken
VA CNH Program staff did not increase monitoring of veterans in substandard CNHs.	Ensure that CNH Program staff increase monitoring of substandard CNHs where veterans are under contract.	**Improved**	An electronic tickler file was established to ensure the timely completion of the required monitoring. The CNH team reviews the Watch List monthly and reports results to the Oversight Committee. Oversight Committee minutes are sent to the Clinical Executive Board (CEB). The social worker and nurse conduct joint monthly visits to homes on the Watch List every 30 days. Although this doubles the number of visits by each discipline, we suggested that alternating the social worker and nurse visits (instead of a joint visit) would further improve the frequency of monitoring. The team was also reminded to increase monitoring of homes that fail the Exclusion Review or those with too many quality measure deficiencies.
The Peer Review Committee (PRC) did not complete the quarterly tracking of peer review activities as required	Ensure that the PRC completes quarterly tracking of peer review activities.	**Resolved**	The summary of PRC findings was revised to include trending of the types of cases that resulted in level 2 and 3 findings.

Report Issues	2006 OIG CAP Report Recommendations	Status as of April 9, 2007	Action(s) Taken
in VHA Directive 2004-054.			The PRC met six times since the CAP visit in June 2006. The minutes reflect discussion of levels assigned to providers, changes to the levels, actions, responsible individuals, and target dates for completion. The PRC presented a summary with levels, findings, trends, and recommendations to the CEB in July and September 2006 and in April 2007.
RCAs did not have measurable outcomes and/or did not measure effectiveness of actions taken. The RCAs did not have concurrence signatures by all appropriate staff.	Ensure that RCAs have measurable outcomes and effectiveness of actions is evaluated. Ensure that RCA team members sign completed RCAs.	**Improved**	RCAs have measurable outcomes with due dates that support the efficacy of action plans. VISN 6 provided training to Patient Safety Managers and plans to review selected action plans within the VISN Patient Safety peer group. The NCPS provides feedback on selected RCAs. RCA team leaders were instructed to obtain all team member signatures prior to presentation to the Medical

Appendix B

Report Issues	2006 OIG CAP Report Recommendations	Status as of April 9, 2007	Action(s) Taken
			Center Director. RCAs we reviewed contained the necessary signatures.
Administrative Boards of Investigation (ABIs) did not have all of the team member signatures and did not include the convening authority certificate of completion.	Ensure all ABIs have certificates of completion and all team members sign the completed reports.	**Resolved**	Certificates of completion were added to all ABIs and the Chairperson of each ABI has been instructed to obtain all member signatures prior to the presentation of the investigation. We reviewed four recent ABIs and found the appropriate documentation.
The main Nutrition and Food Service (N&FS) kitchen ceiling and air diffusers were not clean.	Ensure that the N&FS kitchen ceiling and air diffusers are cleaned regularly and a system for monitoring compliance is in place.	**Resolved**	N&FS added cleaning of air diffusers to weekly cleaning schedule. At the time of our inspection in 2007, the air diffusers were clean. N&FS added the ceiling to their monthly Sanitation/Safety Inspection of the food production area. FMS added air diffusers and sprinkler heads in N&FS kitchen ceiling to its annual preventive maintenance schedule.

Appendix C

VISN 6 Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 26, 2007

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Follow-Up Evaluation of Clinical Issues, W.G. (Bill) Hefner VA Medical Center, Salisbury, NC; Project Number 2007-01796-HI-0323**

To: Office of Inspector General

Thru: Director, Management Review Office (10B5)

1. VISN 6 has reviewed and concurs with the draft report. The VISN Office is closely monitoring completion of the action items related to covering lavatory and supply pipies and that interim measures have been put into place. Also, note that action related to the emergency alert system has been completed.

2. I would also add that if they have questions, please contact the Network Director.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Appendix D

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 25, 2007

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

Subject: **Follow-Up Evaluation of Clinical Issues, W.G. (Bill) Hefner VA Medical Center, Salisbury, NC; Project Number 2007-01796-HI-0323**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

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

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Follow-Up Evaluation 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:)

CAROLYN L. ADAMS

Director, Salisbury VA Medical Center

Appendix D

Medical Center Director Comments

OIG Recommendation(s)

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires that lavatory waste and supply pipes on the mental health units are covered.

Concur **Target Completion Date: October 31, 2007**

The toilets and sinks on the Mental Health units will be retrofitted with a commercially made protective covering to provide patient safety. The estimated cost is $190,000.

The Mental Health Service Line has developed an interim plan with staffing to ensure appropriate supervision/monitoring of patients in areas of high risk e.g. bathrooms, to help ensure patient safety until the structural changes can be made.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director implements an emergency alert system in long connecting tunnels that is accessible to patients, visitors, and staff.

Concur **Target Completion Date: Completed.**

The installation of two way communication emergency call boxes has been completed throughout the tunnel system in Salisbury. The RED Emergency Call Boxes, when activated, will connect the caller to the Telephone Operator who will dispatch the call to the Police Service. They function by pushing a button once to alert the operator which permits two way communications. The four number phone extension of the call box reveals the location of the call. This information has been communicated to all staff.

Appendix E

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	David Griffith Jerome Herbers, M.D. Christa Sisterhen Susan Zarter

Appendix F

Report Distribution

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