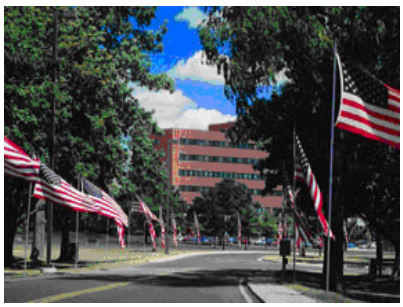
Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01619-216

Combined Assessment Program Review of the Martinsburg VA Medical Center Martinsburg, West Virginia



July 28, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is 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.

Table of Contents

Executive Summary

Introduction

During the week of April 12–15, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Martinsburg VA Medical Center (the medical center), Martinsburg, WV. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 176 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 5.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in six of the activities reviewed; one recommendation was a repeat recommendation from the prior CAP report. For these activities, the medical center needed to:

- Ensure that managers validate competencies annually for all staff performing reprocessing.
- Require staff to don and doff appropriate personal protective equipment (PPE), as required by VA policy.
- Require that validation of competencies, compliance with standard operating procedures (SOPs), results of infection prevention and control monitoring, and risk management related activities are reported to the Executive Committee of the Medical Staff (ECMS), as required.
- Ensure that managers institute appropriate interim measures to improve infection control in the operating room (OR) disinfection room until construction of the new reprocessing areas is completed.
- Require that identified environment of care (EOC) rounds attendance, safety, infection control, environmental hazards training, and respirator fit testing and training concerns be corrected.
- Ensure that discharge instructions include all elements required by Veterans Health Administration (VHA) policy.
- Require that managers implement processes to monitor and evaluate inter-facility transfers.
- Require that designated staff maintain current Basic Life Support (BLS) certification, in accordance with local policy.

- Require that provider privileges reflect the provider's scope of practice.
- Ensure that new employee orientation includes magnetic resonance imaging (MRI) safety training.

The medical center complied with selected standards in the following two activities:

- Medication Management
- Suicide Prevention Safety Plans

This report was prepared under the direction of Donna Giroux, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 15–20, for the full Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

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

Introduction

Profile

Organization. The medical center is a Level II facility located in Martinsburg, WV, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics in Cumberland and Hagerstown, MD; Harrisonburg and Stephens City, VA; and Franklin and Petersburg, WV. The medical center is part of VISN 5 and serves a veteran population of about 123,000 in 23 counties in western Maryland, south central Pennsylvania, northwestern Virginia, and West Virginia.

Programs. The medical center provides primary and secondary care. It has 69 hospital beds and 178 community living center (CLC) beds and a 312-bed domiciliary.

Affiliations. The medical center is affiliated with Eastern West Virginia Health Education Consortium; George Mason University College of Health and Human Services; George Washington University School of Medicine and Health Sciences; Virginia Commonwealth University School of Dentistry; West Virginia School of Osteopathic Medicine; and West Virginia University School of Dentistry. It provides training for 33 residents.

Resources. In FY 2009, medical care expenditures totaled $217 million. The FY 2010 medical care budget is $220 million. FY 2009 staffing was 1,689 full-time employee equivalents (FTE), including 93 physician and 254 nursing FTE.

Workload. In FY 2009, the medical center treated 32,371 unique patients and provided 16,931 inpatient days in the hospital and 48,495 inpatient days in the CLC. The inpatient care workload totaled 3,480 discharges, and the average daily census, including CLC residents, was 179.3. Outpatient workload totaled 380,102 visits.

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 administration 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 patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

- Coordination of Care
- EOC
- Medication Management
- MRI Safety
- Physician Credentialing and Privileging (C&P)
- QM
- Reusable Medical Equipment (RME)
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through April 12, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Martinsburg VA Medical Center, Martinsburg, West Virginia,* Report No. 07-01572-178, July 31, 2007). The medical center had corrected all findings from the prior CAP review except for an EOC issue which is addressed in the EOC section.

During this review, we also presented fraud and integrity awareness briefings to 176 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.

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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The medical center's Central Instrument Processing (CIP)—previously known as Supply, Processing, and Distribution—and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected CIP, the gastrointestinal (GI) clinic reprocessing area located in a mobile unit on campus, and a CIP satellite reprocessing area located in the OR area. We determined that the medical center had established appropriate guidelines and monitored compliance with those guidelines. However, we identified the following areas that needed improvement.

Competencies. VHA policy requires that all employees involved in the use and reprocessing of RME have documented training on the set-up, use, reprocessing, and maintenance of the specific RME leading to initial competency and validation of that competency on an annual basis.[1] We observed the disinfection or sterilization of 10 pieces of RME and reviewed the competency folders of the employees who performed the RME reprocessing. We found that documentation of annual competencies was not

[1] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

current for the employees who cleaned the transesophageal probe, the rectal probe, and a colon scope.

PPE. VA policy requires the use of specific attire that must be donned before entering and doffed before leaving decontamination areas.[2] The specific attire includes impervious shoe covers. We observed staff in the GI clinic mobile unit wearing paper shoe covers, staff accessing the CIP area without appropriate attire, and staff leaving the disinfection area located in the OR without removing PPE.

Reporting Requirements. VHA policy requires that certain elements of the medical center's RME program be reported to the ECMS, including validation of initial and ongoing competency of staff, results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management related activities.[3] We found no evidence of this reporting in committee meeting minutes, and the medical center was unable to provide other documentation of the required reporting.

Ventilation and Air Flow. For infection control purposes, VA policy requires the use of negative ventilation and 6 air exchanges per hour in decontamination areas and the use of positive ventilation and 10 air exchanges per hour in clean areas.[4] Air flow deficiencies existed in the OR disinfection and CIP areas. Current information concerning air flow was not available for the GI mobile unit. The medical center has plans and funds allocated to remodel the CIP area by the end of September 2010 and to relocate the mobile unit to a permanent unit within the medical center by the end of January 2011. After the mobile unit is relocated, the disinfection area in the OR will be closed and moved to the new GI clinic area. Currently, due to the poor air exchange in the disinfection room located in the OR suite, staff do not close the door to the room when reprocessing RME. We recognize that the medical center has definite plans that will address all the current air flow issues; however, leaving the door open while reprocessing in the OR disinfection room is not an appropriate interim measure.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that managers validate

[2] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[3] VHA Directive 2009-004.
[4] VA Handbook 7176.

competencies for all staff performing reprocessing on an annual basis.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that staff don and doff appropriate PPE, as required by VA policy.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that validation of competencies, compliance with SOPs, results of infection prevention and control monitoring, and risk management related activities are reported to the ECMS, as required.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that managers institute appropriate interim measures to improve infection control in the OR disinfection room until construction of the new reprocessing areas is completed.

The VISN and Medical Center Directors concurred with the findings and recommendations. Competencies for staff performing reprocessing have been validated and will be reviewed annually. Proper procedures for PPE were reviewed with staff, and compliance will be monitored. Competency validation, SOP compliance, infection prevention and control monitoring, and risk management activities will be reported to the Infection Control Committee and to the ECMS. Plans have been made to temporarily relocate the OR disinfection room. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We inspected the inpatient units (including the medical-surgical and locked mental health (MH) units and the CLC), the mobile GI procedure area, specialty clinics, the clinical laboratory, and same day surgery. The medical center maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

EOC Rounds. VHA policy requires that the Director or the Associate Director lead EOC rounds.[5] Participants should also include managers in nursing, building management, engineering, safety, patient safety, infection control, and information security. The medical center was unable to provide documentation that the required participants or appropriate designees attended all the semi-annual EOC rounds. This is a repeat finding.

Safety. VHA and OSHA require that eyewash stations and/or showers be available in work areas for emergency use when exposure to corrosive materials, blood, potentially infectious materials, and specified chemicals occurs and that they be maintained and monitored.[6] We inspected 12 eyewash stations and found inconsistencies in monitoring and maintenance of the stations. Additionally, the oncology unit moved to a new location that did not have an eyewash station. Although chemotherapy was performed at this new location, no interim measures (for example, portable eyewash bottles) were provided.

Infection Control. VHA policy and JC standards require documentation and monitoring of hand hygiene practices as a performance improvement (PI) monitor for infection control.[7] Hand hygiene PI monitors fell below established thresholds, and the monitoring process was inconsistent. As a result, the medical center was not able to initiate corrective actions. Although the medical center has taken steps to address these issues, implementation of the action plan requires further monitoring.

Local policy requires that Environmental Management Service employees receive annual training on cleaning and disinfection procedures. We reviewed 10 employee training records. We did not find evidence that the medical center provided the required annual training.

Environmental Hazards Training. VHA policy requires that locked MH unit employees and Multidisciplinary Safety Inspection Team members receive initial and annual training on environmental hazards that represent a threat to suicidal

[5] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[6] VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment;* May 13, 2009.
[7] VHA Directive 2010-006, *Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative*, February 3, 2010.

patients.[8] We reviewed training records and found that 6 (40 percent) of the 15 employees did not have the required annual MH environmental hazards training. In addition, one new employee assigned to the MH unit did not receive initial training.

Respirator Fit Testing. OSHA requires that staff identified to wear an N95 respirator undergo initial and annual fit testing and training. We reviewed N95 respirator fit testing and training documentation and noted that 13 (62 percent) of 21 direct care staff did not receive the required annual N95 respirator fit testing and training.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that the identified EOC rounds attendance, safety, infection control, environmental hazards training, and respirator fit testing and training concerns be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. EOC rounds backup team members were identified, and plans for training have been developed. Rounds attendance will be monitored and reported to the EOC Committee quarterly. Local policy has been revised to include weekly eyewash station inspections, and supervisors will be trained to perform the inspections. Safety will conduct monthly inspections and will report results to the Safety Subcommittee. Portable eyewash bottles were provided to chemotherapy. Hand hygiene education has been enhanced. A standardized monitoring and reporting tool has been implemented, and action plans will be developed. Environmental hazards training has been completed. The respirator fit testing program has been improved to provide better monitoring and tracking of training. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

[8] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," general instructions, January 4, 2010.

VHA requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the facility had an appropriate transfer policy in place. However, we identified the following conditions that needed improvement.

Discharge Instructions. VHA policy requires that providers include information regarding medications, diet, activity level, and follow-up appointments in discharge instructions.[9] We reviewed the medical records of 10 patients who were discharged from acute care during January and February 2010. We found that 5 (50 percent) of the 10 medical records were missing a required element, such as diet or activity level.

Inter-Facility Transfers. VHA and local policies require inter-facility transfers to be monitored and evaluated as part of the QM program.[10] We did not find evidence that the medical center analyzed and trended data for inter-facility transfers.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that staff ensure that discharge instructions include all the elements required by VHA policy.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that managers implement processes to monitor and evaluate inter-facility transfers.

The VISN and Medical Center Directors concurred with the findings and recommendations. The medical center has developed a discharge instruction note template that includes all required elements and will monitor its use. The transfer coordinator is monitoring inter-facility transfers, and reports will be made quarterly to the ECMS. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the medical center's Director, the Chief of Staff, and the QM

[9] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[10] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May, 2007.

Chief. We evaluated plans, policies, PI data, and other relevant documents.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified one area that needed improvement.

Life Support Training. VHA policy requires the medical center to monitor BLS and Advance Cardiac Life Support (ACLS) training and to ensure timely renewal of all certifications.[11] Additionally, the medical center has a local policy addressing the requirements for BLS and ACLS certification. The medical center complied with requirements for ACLS training. For BLS certification, managers had identified 417 employees required to have this certification; however, 46 (11 percent) employees did not have current certificates.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current BLS certification, in accordance with local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center is revising its policy. Service chiefs will be responsible for monitoring staff compliance and maintaining certification documentation. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[12] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been appropriately obtained. The medical staff's Professional Standards Board minutes were excellent

[11] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[12] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

and contained detailed discussions about the physicians in our sample. However, we identified the following area that needed improvement.

Physician Privileging. We identified one provider who was a tele-dermatology consultant. This provider did not work at the medical center but had privileges to do procedures at the medical center. This exceeded the scope of practice for this provider for this medical center.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that provider privileges reflect the provider's scope of practice.

The VISN and Medical Center Directors concurred with the finding and recommendation and modified the provider's privileges to reflect the current scope of practice. The corrective actions are acceptable, and we consider this recommendation closed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff, and are essential to quality patient care.

We inspected the MRI area, examined patient medical records and staff training records, reviewed relevant policies, and interviewed key staff. We determined that the medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC. The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room were directly observed at all times and had access to a push-button call system while in the scanner.

The JC recommends that trained staff screen patients for metal devices, tattoos, and other contraindications. We reviewed the medical records of 10 patients who underwent MRI studies in December 2009 and January 2010. Although screening forms were completed for all patients, two of the screening forms were not scanned into the electronic medical record. While we were onsite, Imaging Service managers addressed these medical records and agreed to monitor compliance with the scanning process. Therefore,

we did not make a recommendation for this finding. However, we identified one area that needed improvement.

MRI Safety Training. The JC recommends providing all medical and ancillary staff who may be expected to accompany patients to the MRI suite with MRI safety education initially at orientation and annually thereafter. We reviewed the training records of six non-MRI employees who have occasional access to Zone III of the MRI suite. We determined that MRI safety education was not provided as part of the employees' initial orientation. The Imaging Service manager plans to incorporate MRI safety training into new employee orientation. However, monitoring of this plan through implementation is needed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that new employee orientation includes MRI safety training.

The VISN and Medical Center Directors concurred with the finding and recommendation. MRI safety training has been added to new employee orientation, and monitoring will be conducted to ensure compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The medical center employed a nephrologist[13] who monitored patients with chronic renal disease receiving erythropoiesis-stimulating agents (ESAs).[14] We reviewed the medical records of 10 patients who received ESAs and found that clinical staff had appropriately identified and addressed elevated hemoglobin levels. We reviewed the medical records of 10 CLC residents for documentation of immunizations during the flu season September 1, 2009–March 31, 2010. In general, influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol

[13] A physician specializing in the treatment of kidney diseases.
[14] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

when a delay in receipt of vaccines was experienced. Additionally, the medical center had pharmacy services available 24 hours a day, 7 days a week. We made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, identify warning signs preceding crisis, and list personal internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[15]

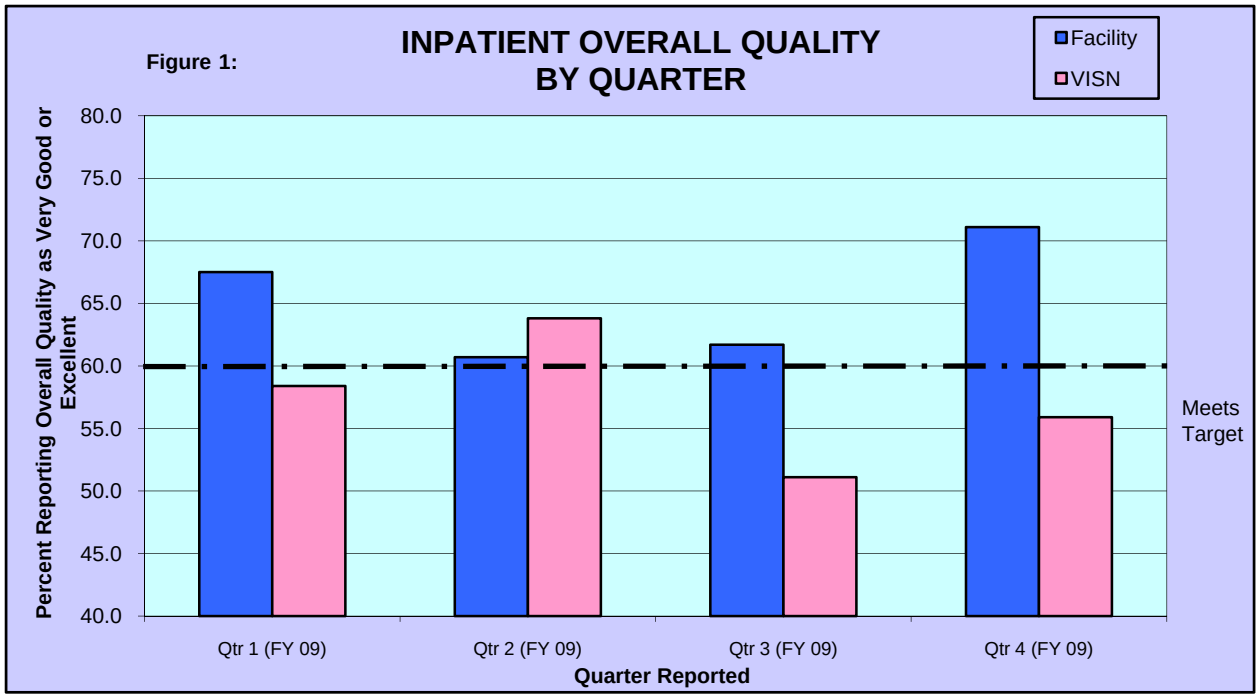
A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development.[16] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

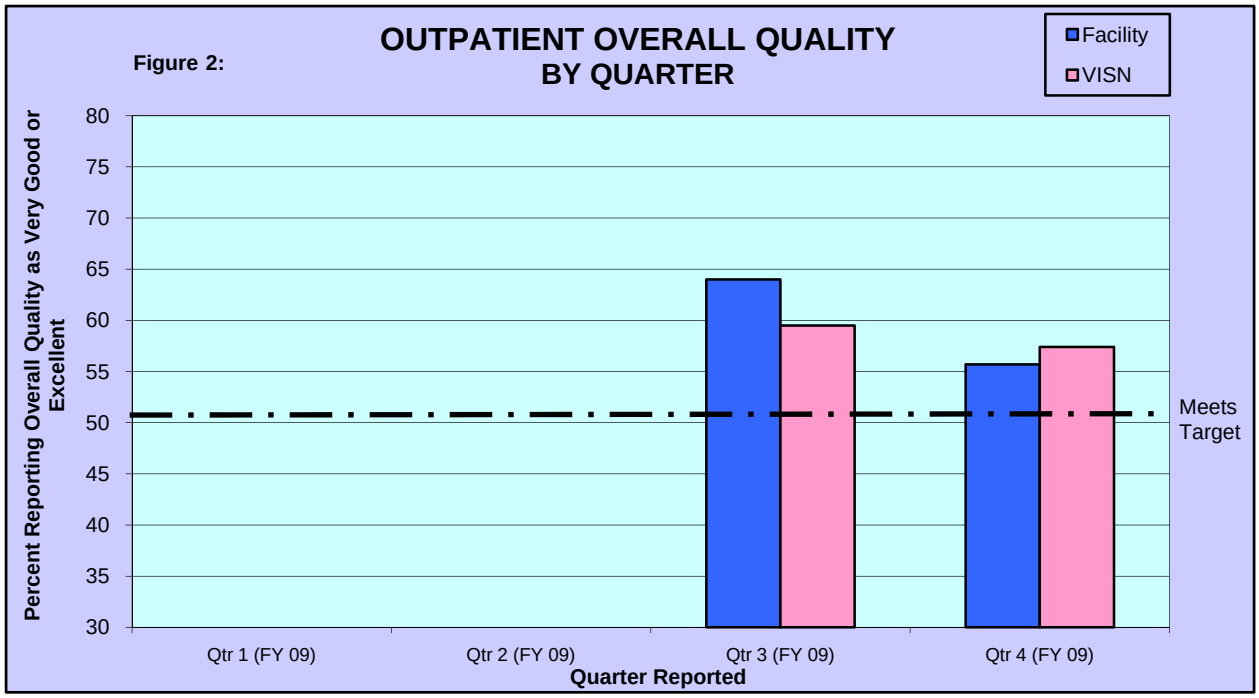
We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[17] The target scores are noted on the graphs.

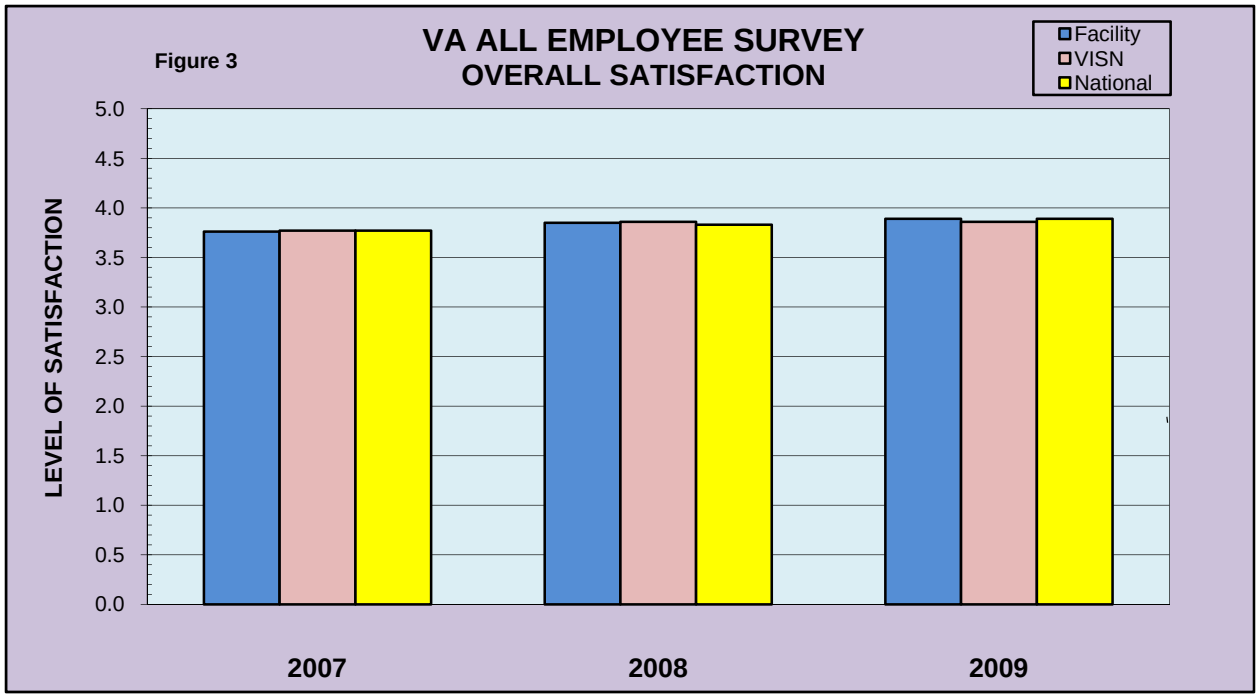
[15] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[16] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[17] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 14, 2010

From: Director, VA Capitol Health Care Network

Subject: **Combined Assessment Program Review of the Martinsburg VA Medical Center, Martinsburg, WV**

To: Associate Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. I have reviewed the comments provided by the Medical Center Director, Martinsburg VA Medical Center and concur with the responses and proposed action plans to the recommendations outlined in the report.

2. We appreciate the opportunity for this review as a continuing process to improve the care to our Veterans. The Office of Inspector General Continuous Assessment Program Team was professional and consultative during the review.

3. If further information is required, please contact V. Denise O'Dell, RN, MSA, CPHQ, Chief Quality Management, Martinsburg VA Medical Center, at (304) 263-0811, extension 4035.

Sanford M. Garfunkel, Network Director

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 14, 2010

From: Director, Martinsburg VA Medical Center

Subject: **Combined Assessment Program Review of the Martinsburg VA Medical Center, Martinsburg, WV**

To: Associate Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. Attached please find the Martinsburg responses and relevant action for the 10 recommendations from the Office of the Inspector General Combined Assessment Program Review Conducted April 12–15, 2010.

2. We found the review educational and helpful in preparation for our upcoming Joint Commission Survey. We appreciate the professionalism demonstrated by the OIG, CAP Team.

3. If you have any questions regarding this report, please contact V. Denise O'Dell, RN, MSA, CPHQ, Chief Quality Management, Martinsburg VAMC, at (304) 263-0811, extension 4035.

Ann R. Brown, FACHE, Director

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 Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that managers validate competencies for all staff performing reprocessing on an annual basis.

Concur

The competencies for staff who clean the trans-esophageal probe, the rectal probe, and the colon scope have been completed and will be performed on an annual basis.

Target Completion Date: Completed, monitoring will continue.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that staff don and doff appropriate PPE, as required by VA policy.

Concur

The requirement for impervious shoe covers was addressed with appropriate personnel. The proper PPE procedure for staff accessing the CIP area and leaving the OR disinfection area was addressed during the April review.

Target Completion Date: Completed, monitoring will continue.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that validation of competencies, compliance with SOPs, results of infection prevention and control monitoring, and risk management related activities are reported to the ECMS, as required.

Concur

Actions regarding validation of staff competencies compliance with SPD SOP's were addressed in response to Recommendations 1. The RME reporting, which includes competency validation, SOP compliance, infection prevention and monitoring, and risk management activities to Infection Control and then to ECMS began May 24, 2010. The reporting to ECMS will continue quarterly.

Target Completion Date: Completed.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that managers institute appropriate interim measures to improve infection control in the OR disinfection room until construction of the new reprocessing areas is completed.

Concur

Construction is underway to address this area. In Sept. 2010 CIP will go into a temporary space with adequate ventilation and air flow. In Jan. 2011 OR disinfection will move to a new CI clinic area.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the identified EOC rounds attendance, safety, infection control, environmental hazards training, and respirator fit testing and training concerns be corrected.

Concur

All EOC Rounds team members have now identified a backup member. The backup members will be trained within 60 days. EOC rounds member attendance will be monitored and reported to the EOC Council quarterly.

MCM 001S-18 “Emergency Eyewash and Shower Equipment” has been revised to include weekly inspections of the eyewash station/shower by supervisors. Safety section will be providing training to supervisors; steps for inspecting eyewash stations/showers. Also, Safety section will be posting signage at each eyewash station/shower on procedures for testing. Additionally, Safety section will complete monthly inspections of eyewash stations/showers. Safety section will monitor and report to the Safety Sub-Committee. Portable eyewash bottles were provided to the chemotherapy area immediately as an interim measure until moving to their permanent location which will have an eyewash station.

The hand hygiene education for staff on the nursing units, as well as new employee orientation has been enhanced to include a broader scope of infection control knowledge, including competency for Hand Hygiene with a return demonstration, use of the Glitter Bug hand hygiene teaching aide and new educational hand hygiene handouts for staff. Standardized and hygiene monitoring tool and reporting mechanism has been implemented for tracking compliance to be followed with action plans by the MRSA Coordinators on a consistent basis.

MSIT training has been completed for all 15 employees including the new employee receiving initial training. Annual MSIT refresher training has been added to LMS.

A Respirator Fit Testing program was in place at the time of review. However, a more comprehensive respiratory management protection process has been developed to ensure improved oversight Fit testing completion is now documented in VA Learning Management System (LMS) and monitored by the supervisor.

Target Completion Date: Sept. 3, 2010

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff ensure that discharge instructions include all the elements required by VHA policy.

Concur

The Medical Center has a Discharge Note template that covers the discharge instruction required elements. The Clinical Service Chiefs are to review utilization of the proper Discharge Note template with providers within 60 days. This has been added to the service clinical pertinence reviews for continued monitoring.

Target Completion Date: Sept. 3, 2010

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that managers implement processes to monitor and evaluate inter-facility transfers.

Concur

The Transfer Coordinator was monitoring inter-facility transfers at the time of the review and then information was shared with Clinical Service Chiefs and the Chief of Staff. A quarterly reporting schedule has been added to ECMS beginning in June 2010.

Target Completion Date: June 30, 2010 with continued monitoring.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that designated staff maintain current BLS certification, in accordance with local policy.

Concur

89% of the MC staff required to have BLS certification were found to be certified during the review. Martinsburg VA Medical Center has revised the facility memorandum 11-46 Basic Life Support Policy and it is in the approval process. The memorandum specifically identifies BLS certification requirements for specific clinical staff. Service Chiefs/Supervisors are responsible for monitoring staff compliance and

maintaining certification documentation in employee competency folders or provider files.

Target Completion Date: September 1, 2010 for memorandum approval and implementation.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that provider privileges reflect the provider's scope of practice.

Concur

That providers privileges were corrected at the May, 2010 PSB meeting. Clinical Service Chiefs were also reminded to review "setting specific" privileges prior to renewal at that same May PSB meeting.

Target Completion Date: Completed.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that new employee orientation includes MRI safety training.

Concur

MRI Safety training has been added to new employee orientation and will be recorded in LMS.

Target Completion Date: Completed, monitoring will continue.

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