Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02383-27

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

November 10, 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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
CNH	contract nursing home
COC	coordination of care
ED	emergency department
EOC	environment of care
facility	Beckley VA Medical Center
FMSL	Facilities Management Service Line
FTE	full-time employee equivalents
FY	fiscal year
ICU	intensive care unit
JC	Joint Commission
MRI	magnetic resonance imaging
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OR	operating room
OSHA	Occupational Safety and Health Administration
PPE	personal protective equipment
PRF	patient record flag
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RME	reusable medical equipment
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Beckley VA Medical Center, Beckley, WV

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 26, 2010.

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

- Medication Management
- Quality Management

The facility's reported accomplishment was the implementation of zone maintenance to improve timely completion of work orders.

Recommendations: We made recommendations in the following six activities:

Coordination of Care: Complete inter-facility transfer and discharge documentation in accordance with Veterans Health Administration policy. Provide written discharge instructions to patients.

Physician Credentialing and Privileging: Ensure that all privileges granted are facility and setting specific.

Environment of Care: Ensure comprehensive oversight and monitoring of the hemodialysis contract. Provide eyewash stations as necessary. Implement a comprehensive respirator fit program.

Magnetic Resonance Imaging Safety: Conduct quarterly fire drill evaluations.

Reusable Medical Equipment: Maintain the required humidity range in Supply, Processing, and Distribution and the required air exchanges in Supply, Processing, and Distribution and the operating room decontamination area. Utilize interim plans for the operating room decontamination area until the construction project has been completed.

Suicide Prevention Safety Plans: Place appropriate flags in patient records, and develop timely, comprehensive safety plans. Provide the patient or family with a copy of the plan.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

Objectives and Scope

Objectives

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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through June 30, 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 facility (*Combined Assessment Program Review of the VA Medical Center, Beckley, West Virginia,* Report No. 06-03479-07, October 19, 2006). The facility had corrected all findings.

During this review, we also presented crime awareness briefings for 514 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.

Reported Accomplishment

Zone Maintenance

VISN 6 developed and implemented a model for zone maintenance coverage of all clinical areas at each medical center in the VISN. Each medical center uses an algorithm of space, age, staff levels, and complexity to determine/assign the zones. Maintenance mechanic workers are assigned sections of zones as the first point of contact for work in these areas. Zone workers enter a work order and handle the work themselves, or they coordinate the work to be done with other personnel. These employees are essentially the personal "handymen" of their zones.

Results

Review Activities With Recommendations

COC

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.

VHA[1] requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

[1] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

However, we identified the following conditions that needed improvement.

Inter-Facility Transfers. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's acute medical unit and ED to another facility. We found that providers did not document all the required information for 4 (40 percent) of the 10 patients. Missing information included documentation of the advanced directive, level of services/care required, and requirements during transport.

Discharges. VHA[2] requires that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. In addition, The JC requires that clinicians provide patients with written discharge instructions. We reviewed the medical records of 15 discharged patients and found that 1 patient (7 percent) did not have discharge instructions. In addition 4 (29 percent) of the 14 records with discharge instructions had no documentation that the patients or family members received written discharge instructions.

Recommendations

1. We recommended that providers complete inter-facility transfer documentation in accordance with VHA policy.

2. We recommended that providers complete discharge documentation in accordance with VHA policy and that patients receive written discharge instructions.

Physician C&P

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 physician profiles. 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. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service specific criteria for Ongoing Professional Practice Evaluation had been developed and approved.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. However we identified the following area that needed improvement.

Privileges. VHA[3] requires that privileges granted to a provider be facility specific, service specific, and provider specific. Privileges granted to one provider were beyond the capabilities of the facility, and another provider had privileges to perform surgical procedures in a clinic setting, which is not the appropriate setting for these privileges.

Recommendation

3. We recommended that all privileges granted are facility and setting specific.

EOC

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, NFPA, and JC standards.

We inspected the CLC on the 4th and 6th floors, Units 3A and 3B, the ICU, prosthetics, the 4th floor dialysis areas, the ED, and the laboratory and outpatient pharmacy areas. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement:

Hemodialysis Services. VA policy[4] requires that care provided under a health care resources contract meet VA quality standards of care. The facility has contracted with a private company to provide inpatient hemodialysis services. Eight contracted nurses are available to provide inpatient services. The contract mandates several areas of annual training for nursing staff. Four of the eight contracted nurses were oriented to the facility's policies more than 1 year ago, but their folders did not contain evidence of all elements of the current annual training requirements.

According to the contract, the contracted agent is responsible for completing background investigations. However, VA policy[5] requires that contract personnel be subject to the same investigatory requirements as those for

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[4] VA Directive 1663; *Health Care Resources Contracting – Buying, Title 38 U.S.C. 8153*; August 10, 2006.
[5] VA Handbook 0710, *Personnel Suitability and Security Program,* September 10, 2004.

regular VA employees and that the VA Security and Investigations Center initiate and adjudicate background investigations of contract personnel. While the contracted agency had provided the facility documentation of its background investigation, the VA Contracting Office for the facility had not initiated background checks for the eight contracted nurses.

The Association for the Advancement of Medical Instrumentation requires monthly testing and continued monitoring of hemodialysis water systems. VA policy[6] requires that care provided under a health care resources contract meet VA quality standards of care, which includes appropriately collecting and monitoring data. Contracted nursing staff collected and tested water and dialysate samples on a monthly basis and re-tested appropriately when results were abnormal; however, neither the contracted agency nor the facility tracked and trended the results.

Safety. VHA policy[7] requires that eyewash stations and/or showers be provided for emergency use in work areas where exposure to corrosive materials, blood, potentially infectious materials, and specified chemicals may occur. An eyewash station was not present on the 4th floor where the internal pathways of the dialysis machines are cleaned, nor was there an eyewash station in close proximity to two of the three units where inpatient dialysis takes place.

Respirator Fit Testing. OSHA requires that staff identified to wear an N95 respirator undergo initial and annual fit testing and training. We reviewed the records of 20 staff members who are considered to be high risk for exposure to airborne pathogens that would require respiratory protection. Three (15 percent) of the 20 staff members were not included in the facility's respiratory protection program. Of the remaining 17 staff members, 16 (94 percent) had not undergone annual fit testing and training. The facility had difficulty obtaining an adequate supply of N95 masks during the 2009 flu season and had suspended its N95 respirator fit testing and training program.

Additionally, two of the facility's policies relating to the respiratory protection program were not consistent with

[6] VA Directive 1663; *Health Care Resources Contracting – Buying, Title 38 U.S.C. 8153*; August 10, 2006.
[7] VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.

current practice. The Respiratory Protection Program policy requires bi-annual medical review/evaluation of staff in the program, but the facility's practice is to conduct an annual evaluation. In the Exposure Control Plan policy, the facility indicated that N95 respirators are to be used for acid fast bacillus (tuberculosis) protection only. While we were onsite, the facility acknowledged that N95 masks are used for airborne pathogens other than tuberculosis.

Recommendations

4. We recommended that the facility ensures comprehensive oversight and monitoring of the hemodialysis contract.

5. We recommended that eyewash stations be provided for emergency use in accordance with VHA policy.

6. We recommended that a comprehensive respirator fit program be implemented.

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care. Prior to June 2009, the facility had contracted to have a mobile MRI unit on the campus twice a week to perform scans. In June 2009, the facility purchased a mobile unit and converted it into a stationary unit in order to perform imaging daily during regular business hours.

We inspected the MRI unit, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The facility had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI unit. Patients in the magnet room were directly observed at all times. Two-way communication was available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner.

Local policy requires that personnel who have access to the MRI unit receive appropriate MRI safety training. We reviewed the training records of 12 personnel and found that all had completed required safety training. In addition, we reviewed the medical records of 10 patients who received an

MRI. In all cases, patients received adequate screening. However, we identified the following area that needed improvement.

Fire Safety. NFPA standards require quarterly fire drill evaluations of outpatient care areas. A fire drill evaluation has not been conducted in the MRI unit in the past year.

Recommendation

7. We recommended that quarterly fire drill evaluations be conducted in the MRI unit in accordance with NFPA guidelines.

RME

The purpose of this review was to evaluate whether the facility 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 facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD, OR, and cystoscopy areas. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines. In general, we found that SOPs were current and consistent with the manufacturers' instructions. Also, employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who demonstrated or verbalized the cleaning procedures and found that annual competencies were current and consistently documented. However, we identified the following areas that needed improvement.

Air Quality. VA policy[8] requires that humidity be controlled and maintained between 35 and 75 percent in all areas of SPD. We reviewed electronic reports of humidity levels from July 14–27, 2010, and found that humidity was out of range for all 27 entries for the SPD supply area and for 15 (56 percent) of the 27 entries for the SPD preparation area.

Air Flow. VA policy[9] requires specific air flow and air exchanges in the decontamination and sterile (clean) storage

[8] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements;* August 16, 2002.
[9] VA Handbook 7176.

areas of SPD to minimize cross-contamination from dirty to clean areas. Clean areas are required to have 10 air exchanges per hour, and decontamination areas are required to have 6 air exchanges per hour. We reviewed documentation of testing and determined that the SPD clean area and the OR decontamination area did not meet the required number of air exchanges.

OR Decontamination Area. VA policy[10] requires that traffic to decontamination areas be restricted to authorized personnel and that staff wear PPE at all times while in the decontamination area. VA also requires that there is a physical separation of dirty and clean areas to assist in the prevention of cross-contamination. VHA policy[11] requires that all emergency eyewash stations deliver tepid water.

During our tour of the OR decontamination area, we found that:

- The decontamination area was not restricted to authorized personnel because of its location.
- An employee walked through the decontamination area without the appropriate PPE.
- The decontamination area was open to sterile storage areas and the hallway.
- The flash sterilizer (a machine that provides a shorter sterilization process) was located in the decontamination area.
- The eyewash station in the decontamination area was located on a faucet with a cold and hot control.

The facility had self-identified problems with the OR decontamination area and was in the design phase of a construction project to move decontamination to a renovated endoscopy suite. While we were onsite, the facility developed plans to relocate the OR decontamination area to an area in the hospital that would meet VA policy until the endoscopy suite renovation was completed.

[10] VA Handbook 7176.
[11] VHA Directive 2009-026.

Recommendations

8. We recommended that the humidity range in SPD be maintained in accordance with VA policy.

9. We recommended that air exchanges in SPD and the OR decontamination area are maintained in accordance with VA policy.

10. We recommended that interim plans for the OR decontamination area be utilized until the construction project is completed.

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.[12] Once a patient is identified as high risk, a PRF should be placed in the patient's electronic medical record.[13]

A previous OIG review of suicide prevention programs in VHA facilities[14] found a 74 percent compliance rate with safety plan development. 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 identified the following area that needed improvement.

Safety Plans and PRFs. We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that:

- One patient did not have a plan.

[12] Deputy Under Secretary for Health for Operations and Management, "*Patients at High-Risk for Suicide*," memorandum, April 24, 2008.
[13] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008.
[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

- Of the nine patients who had plans, seven patients/family members did not receive a copy of the plan.

- Six of the nine patient records with plans did not have a PRF placed upon identification of their high-risk status.

- The time from placement on the high risk for suicide list to safety plan development was delayed for four of the nine patients who had plans.

Recommendation

11. We recommended that the PRF be placed when a patient is identified as high risk for suicide; that clinicians develop timely, comprehensive safety plans for all patients identified as high risk for suicide; and that patients and/or family members receive a copy of the safety plan.

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 facility had implemented a practice guideline governing the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[15] We reviewed the medical records of 10 patients who received erythropoiesis-stimulating agents and found that clinical staff had appropriately identified and addressed elevated hemoglobin levels for all 10 patients. Influenza vaccinations were documented adequately for CLC residents, and clinical staff followed the established protocol when a delay in receipt of vaccines was experienced. Also, although the pharmacy is closed from 6:00 p.m. to 7:00 a.m. on weekdays and between 3:30 p.m. and 7:00 a.m. on Saturday, Sunday, and holidays, we found that the facility had made appropriate arrangements with another VA facility to provide pharmacy services when the facility's pharmacy was closed. We made no recommendations.

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the

[15] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

facility's Director, Chief of Staff, and Chief of QM. We also interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents.

The facility's QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Root cause analyses were being completed in a timely manner. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 16–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are complete.

Facility Profile[16]		
Type of Organization	General medical surgical facility	
Complexity Level	3	
VISN	6	
CBOCs	None	
Veteran Population in Catchment Area	36,075	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	40	
• **CLC/Nursing Home Care Unit**	50	
Medical School Affiliation(s)	West Virginia School of Osteopathic Medicine	
• **Number of Residents**	1	
	Current FY (through May 2010)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$95	$98
• **Medical Care Expenditures**	$54	$77
Total Medical Care FTE	677.8	649.2
Workload:		
• **Number of Station Level Unique Patients**	12,462	13,486
• **Inpatient Days of Care:**		
o **Acute Care**	5,742	10,906
o **CLC/Nursing Home Care Unit**	10,401	13,721
Hospital Discharges	1,043	1,831
Total Average Daily Census (including all bed types)	65.6	67.5
Cumulative Occupancy Rate	71.5%	76%
Outpatient Visits	98,076	147,658

[16] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
CNH Program			
1a. Require that the CNH Review Team Coordinator document the findings and recommendations of each CNH review. b. Include quality management and acquisitions representation on the CNH Oversight Committee. c. Use the VA CNH website evaluation tools to report adverse events, and improve communication between nursing homes and CNH program managers. d. Amend local policy to incorporate recommended changes to the program and to meet VHA requirements.	a. Recommendations from each review are documented in the oversight committee meeting minutes. b. CNH Oversight Committee membership was revised and now meets VHA requirements. c. The VA CNH website is continuously updated to include all current facility reviews and to report adverse events. A letter was sent to all administrators and directors of nursing to remind/reinforce the types of events that should be reported immediately. d. Local policy was revised to incorporate recommended changes and to meet VHA requirements.	Y	N
EOC			
2. Increase EOC monitoring and surveillance of construction areas for possible inclusion in the facility's Interim Life Safety Measures.	The construction hazard recognition and control policy now requires the FMSL Chief and/or Assistant Chief of FMSL and a multidisciplinary team to conduct a walk-through of all contractor occupied areas at least monthly. The FMSL Chief conducts the required walk-throughs. Issues are identified during the walk through.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
CBOCs			
3. Improve Contracting Officer Technical Representative oversight of the CBOC.	The facility no longer has a CBOC.	Y	N

VHA Satisfaction Surveys

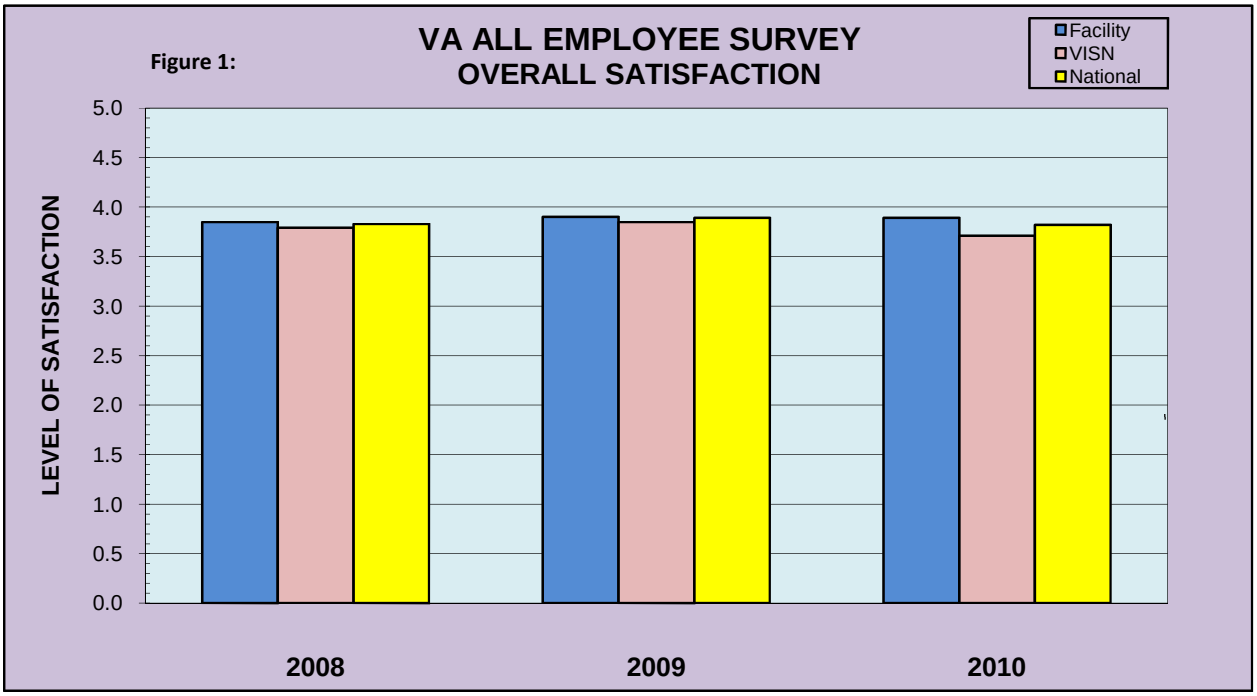
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	65.12	34.07	50.0	67.2	57.0	55.3
VISN	63.53	50.09	59.9	65.7	50.7	50.9
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 09/13/2010

From: VISN Director

Subject: **CAP Review of the Beckley VA Medical Center, Beckley WV**

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

Director, Management Review Service (VHA CO 10B5 Staff)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review on July 26–29, 2010.

2. I have reviewed the draft report for the VA Medical Center, Beckley, WV, and concur with the findings and recommendations.

3. Please express my thanks to the Survey Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our veterans.

(original signed by:)
Daniel F. Hoffmann, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 9/10/10

From: Karin L. McGraw, MSN, FACHE

Subject: **CAP Review of the Beckley VA Medical Center, Beckley, WV]**

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review on July 26–29, 2010.

2. I have reviewed the draft report for the VA Medical Center, Beckley, WV, and concur with the findings and recommendations.

3. Please express my gratitude to the Survey Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our veterans.

(original signed by:)
Karin L. McGraw, MSN, 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 providers complete inter-facility transfer documentation in accordance with VHA policy.

Concur

Target Date for Completion: Template changes and education of staff completed by August 16, 2010. Compliance with documentation monitoring will occur from September 13 through December 31, 2010.

Action taken:

The CAC, CPRS, contacted the VISN office to request a change in the inter-facility transfer note. The CAC, CPRS, requested that the following fields be made mandatory or required fields to ensure that they are always addressed during a patient transfer. The CAC, CPRS, made the changes on the inter-facility transfer note by August 7, 2010. The following fields on the inter-facility transfer note are now mandatory fields:

- Advance Directives
- Level of service/care required
- Medical and/or behavioral stability
- Mode of transportation
- Requirements during transport

All physicians were re-educated on the inter-facility transfer note by August 16, 2010. Monitoring for compliance will be completed by the Health Administration Service. The HAS will monitor a minimum of 30 interfacility transfer notes per quarter for compliance with the VHA policy requirements. Monitoring will begin effective September 13, 2010, and will continue through December 31, 2010. Continuation of measuring for compliance will be re-evaluated after the initial review period.

Recommendation 2. We recommended that providers complete discharge documentation in accordance with VHA policy and that patients receive written discharge instructions.

Concur

Target Date for Completion: Will be implemented by September 30, 2010. Monthly monitoring will occur effective October 1–December 31, 2010.

Action taken:

All discharges from the Long Term care Unit and the Acute Care Inpatient units will have a copy of discharge instructions signed by each patient prior to discharge home verifying they understand and have received a copy of their discharge instructions. This signed document will be scanned into the patient's medical record. The scanned note title is "Patient Confirmation of Discharge Instructions Scanned." Staff will be educated and implement this process, on all units, by September 30, 2010. Monthly monitoring for compliance will begin October 2010. One hundred percent of discharged patients from the above units will be reviewed for compliance the first month post implementation; then random compliance will be assessed in November and December 2010; the denominator will be at least 50 percent of the total discharges in November and December 2010.

Staff Ward Clerk Education: Beginning September 7, 2010, the "Patient Confirmation of Discharge Instructions Scanned" note title is available for use. The document that is scanned under this title is the discharged instruction sheet that is signed by the patient; it is a two page document; this is to be scanned immediately when signed by the patient.

Recommendation 3. We recommended that all privileges granted are facility and setting specific.

Concur

Target Date for Completion: This action was completed effective August 16, 2010, per signature of the Director's concurrence of the Professional Standard Board Committee minutes.

Action taken: The first provider was an orthopedic surgeon that had the special privilege of knee and hip joint replacements. This privilege is not done at our facility. The orthopedic surgeon privileges were revised removing the number requirement on the special privileges and removing the knee and hip joint replacement. A memo was written to the provider informing him of the administrative removal of this special privilege and a copy was placed in his file.

The second provider was a vascular surgeon that had requested special privileges, but the settings initialed were inappropriate. The OR setting was not indicated on the form. A pen and ink change on the provider's privileges was made adding the OR setting. The privileging form was also revised to include the OR setting and remove the numbers column on the special privileges grid. A memo was written to the provider informing him of the correction of the administrative error and that the form is now revised and that the revised form would be used the next privilege period.

Both of these items were addressed and recommendations made for approval at the PSB on August 16, 2010.

Recommendation 4. We recommended that the facility ensures comprehensive oversight and monitoring of the hemodialysis contract.

Concur

Target Date for Completion: Hemodialysis Services – FY 2011; Background Checks – September 17, 2010; and Monthly testing and continued monitoring of hemodialysis water systems – FY 2011.

Action taken:

Hemodialysis Services: In collaboration with the Education Department, annual review training for the contract staff (nurses and technicians) will be offered four times a year to entail the elements of the contract: a) Fire and Safety policy and procedure; b) Infection control policy and procedure; c) Emergency preparedness/disaster policy and procedure; d) Initial competence assessment and other VA mandatory training requirements; and e) Compliance related training. This action plan will be implemented FY 2011.

The contract staff competency folders will be reviewed monthly.

Background Checks: This action plan has been initiated with all eight contracted staff. Four have completed the investigative packages for the Department of Veterans Affairs Background Investigations. The contract staff packages (4) were mailed to VA Security Investigations Center 2200 Fort Roots Drive, Bldg 192/Contractor North Little Rock, AR 72114, when completed. The remaining four are to be completed by September 17, 2010, and will be mailed to the address above. The Background Investigative package will henceforth be initiated at the same time the employee begins the Vet Pro process.

Monthly testing and continued monitoring of hemodialysis water systems: The contracted agency will provide the results of the hemodialysis water cultures to the BVAMC contracting officer technical representative (COTR) monthly. The BVAMC COTR will monitor these results through a spread sheet specific to the two dialysis machines. The contract will have an addendum to the time frame that an action must be taken within 48 hours when abnormal results are noted from the contracted agency. This addendum will be initiated to the Contracting Officer by F2011 first quarter. The monitoring results will be reviewed and submitted to the Infection Control Committee monthly.

Recommendation 5. We recommended that eyewash stations be provided for emergency use in accordance with VHA policy.

Concur

Target Date for Completion: October 1, 2010

Action taken: Safety staff conducted a risk assessment of the entire dialysis unit and determined that an eyewash station was required in the dialysis machine cleaning room due to the use of cleaning corrosives. A self-contained eyewash system meeting VHA standards will be installed in the dialysis machine cleaning room and will be inspected in conformance with all other eyewash stations. Each dialysis treatment room will be equipped to provide staff with a means of flushing mucus membranes or fast drenching of the eyes in accordance with VHA Policy.

Recommendation 6. We recommended that a comprehensive respirator fit program be implemented.

Concur

Target Date for Completion: January 1, 2011

Action taken: The respiratory protection policy has been modified to reflect annual respirator fit-testing and medical review instead of biannual. The exposure control policy has been modified to reflect a more broad use of N95 respirators that will fully encompass our current practice of respiratory protection. N95 respirators have been purchased and are onsite, however we have not distributed them to the entire medical center since the entire roster is not properly fit-tested. At this time we have distributed N95 respirators to the areas with isolation capability and they are being fit-tested as they arrive to work. FIT Testing began on September 8, 2010 with the inpatient units (Ward 3A, 3B, and ICU). To date a total of 39 employees have been FIT-tested with the N-95 respirators. A list of approved N-95 users has been sent to the supervisors and all other personnel are required to use the Powered Air Purifying Respirators as respiratory protection until they are compliant with the program requirements.

Recommendation 7. We recommended that quarterly fire drill evaluations be conducted in the MRI unit in accordance with NFPA guidelines.

Concur:

Target Date for Completion: September 10, 2010

Action taken: A MRI Fire drill was conducted on 9-10-2010, and the MRI trailer will be included in the quarterly day shift medical center wide fire drills.

Recommendation 8. We recommended that the humidity range in SPD be maintained in accordance with VA policy.

Concur

Target Date for Completion: May 2012

Action taken: This will be corrected with project 517-10-111, Corrections to SPD and the OR. This project will be studied in FY 10 and FY 11, designed in FY 11 and FY 12, and constructed in FY 12 (dependent on funds).

Temporary Corrective Action: SPD humidity levels recorded and reviewed in the month of July indicated high humidity levels due to the ambient humidity levels experienced in our geographic area during the warm/humid months. However, beginning around November of each year and extending throughout the cooler low humidity level months, our SPD area experiences humidity levels below the permissible percentages. The above-mentioned contract will replace the air handling system in this area and will achieve the required temperature/humidity requirements for all SPD areas. However, since the estimated project completion data is CY 2012, the facility will implement the following temporary modifications to achieve more controllable indoor environmental conditions. In the upcoming cooler low humidity season, the facility will adjust the humidity levels by installing area humidifiers via our low pressure steam system located in this area. These humidifiers will be dynamic to accommodate the seasonal ambient temperature/humidity levels experience in our geographic location. As the cooler/dryer months begin to fade and warmer and more humid conditions approach, the medical center will reduce the temperature of the chilled water system and therefore reduce the amount of moisture being delivered to the SPD area. Engineering and HVAC feel that these modifications can temporarily alleviate exceeding temperature and humidity parameters detailed in VHA Policy.

Humidity Readings	Current	Daily	Yearly
BC-108 (Decon)	51.7%	55%	45%
BC-108I (Sterile Storage)	61%	64%	48%
BA-103	46.3%	54%	60%

Temporary Corrective Action Target Date for Completion:

Installation of Humidifiers: 11-15-2010

Lower Chill Water Temperature: As Required

Installation of new Air Handler April, 2011: Note this unit is same size but is new and more efficient so will provide better air flow and humidity control.

Recommendation 9. We recommended that air exchanges in SPD and the OR decontamination area are maintained in accordance with VA policy.

Concur

Target Date for Completion: May 2012

Action taken: This will be correct with project 517-10-111, Corrections to SPD and the OR. This project will be studied FY10 and FY11 designed n FY 11 and FY 12 and constructed FY 12.

Temporary Corrective Action:

The air exchanges per hour (ACH) in the SPD area as follows:

	Area ft^2	Height ft	Vol ft^3	Air ft^3 / min	Air ft^3 / hr (calculated)	Air exchanges per hour	Required
BC-108	2172	8	17376	2433	145980	8.4	10
BC-108I	960	8	7680	1626	97560	12.7	10
BA-103	715	8	5720	1220	73200	12.8	6

As you can see Room BC-108 (decon) is 1.6 ACH below the required value and BA-103 (sterile prep) is 6.8 ACH above the required value. Attempts are being made to reduce the ACH in BA-103 and adjust the supply/exhaust in BC-108 to redirect excessive air flow into BA-103. Following these air handling and ducting modifications the HVAC specialists will recalculate the ACH in these locations to document the new ACH. Engineering and the HVAC specialist feel confident these modifications can be made and will temporarily alleviate the deficient ACH in BC-108. Project 517-10-111 is designed to replace the air handling unit with a new more efficient system capable of meeting all VHA Policy requirements for ACH in the SPD area.

The OR Decontamination area within the OR suite on the 5th floor is being relocated into the SPD decontamination room located in BC-108. This decision was based on multiple indoor environmental conditions and infection control techniques. During the OIG survey this transition immediately began through renovation of BC-108 to accommodate the Steris machines and a double bowl stainless steel sink. The renovations to accommodate the equipment and sink are complete, however, the medical center is currently waiting on Emergency Transaction # 517-10-4-084-0155 (vendor is Getinge) which was approved and left Beckley VAMC on 9-2-2010 however has not been approved through contracting in Hampton VA. This project through Getinge is to relocate a pass through window to be used to properly transport clean equipment from the Steris Machine into the preparation area. Following this project's approval, scheduling with Getinge and pass through window installed/relocated BC-108 will ready to accept the OR decontamination process. At that time the OR Decontamination process will be terminated and therefore eliminate the ACH Deficiency in the current OR decontamination area noted during the OIG Survey.

Temporary Corrective Action Target Date for Completion:

In House Modifications to BA-103 Decon Area: Complete

Modifications to Existing Air Handler: September 24, 2010

Installation of new Air Handler – April 2011. **Note:** This unit is the same size, but is new and more efficient so it will provide better air flow and humidity control.

Installation of pass through window: 10/31 (Pending Contracts)

Recommendation 10. We recommended that interim plans for the OR decontamination area be utilized until the construction project is completed.

Concur

Target Date for Completion: December 2010

Action taken: VAMC Engineering immediately began relocating the scope cleaning process to the SPD decontamination area in the basement and is nearly 100% complete with the area redesign. Beckley VAMC station funds were used to renovate the SPD area to accommodate the scope cleaning processes being removed from the OR. An Emergency Purchase Order was submitted to Purchasing to complete the renovation by relocating the pass through window and replacing stainless steel. The project will be completed this calendar year, however, an exact completion date can't be provided at this time. The faucet mounted eyewashes will be removed and a single unit eyewash meeting ANSI standards will be placed in the hallway within the OR suite. An unused water fountain will be removed and this eyewash will take its place. The eyewash has been ordered, received, and installation began and will be completed 9-10-10.

To ensure the required PPE is donned prior to entering the decontamination area in SPD, the OR supervisor and Chief SPD will complete random weekly checks to ensure the requirements are adhered to.

Recommendation 11. We recommended that the PRF be placed when a patient is identified as high risk for suicide; that clinicians develop timely, comprehensive safety plans for all patients identified as high risk for suicide; and that patients and/or family members receive a copy of the safety plan.

Concur:

Target Date for Completion: Target date for completion will be September 30, 2010. This will be monitored monthly through December 31, 2010.

Action taken:

1. Recommendation that a PRF be placed when a patient is identified as high risk.
   a. The Suicide Prevention Coordinator will place the flag on the chart, when the Prevention Team identifies a patient as high risk.
   b. A CPRS note will document the flag placement.
   c. A Safety Plan will be developed as soon as the Prevention Team or clinician sees the high risk patient face-to-face.

2. Recommendation that clinicians develop timely, comprehensive safety plans for all patients identified as high risk for suicide.
   a. As soon as the patient is identified and presents to the medical center mental health clinic, the Prevention Team and/or Mental Health Clinician will develop the Safety Plan with the patient and family members.
   b. The patient and/or family members will collaborate with the Prevention Team and/or Mental Health Clinician what warning signs and what actions can be taken to prevent a suicidal action. The plan will include all phone numbers the patient and his family can call for help and advice.
3. Recommendation that patients identified at high risk for suicide and/or family members receive a copy of the safety plan.
   a. The Safety Plan Template has been modified to check off that the patient and/or family members have been given a copy of the Safety Plan.

MEASUREMENT OF ACTIONS

Each month the Suicide Prevention Coordinator and Suicide Prevention Case Manager will review the patients identified as high risk patients for documentation of the following: A Patient Record Flag, a Safety Plan, and documentation that a copy of the Safety Plan was given to the patient and/or family members. This data will be aggregated quarterly. The review period will be October 1, 2010–December 31, 2010.

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