Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00883-189

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

May 30, 2012

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

CAP	Combined Assessment Program
CRC	colorectal cancer
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Beckley VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
IC	infection control
JC	Joint Commission
MEC	Medical Executive Committee
OIG	Office of Inspector General
POCT	point-of-care testing
PUMA	Physician Utilization Management Advisor
QM	quality management
SCI	spinal cord injury
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 April 16, 2012.

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

- Coordination of Care
- Medication Management
- Moderate Sedation
- Nurse Staffing
- Point-of-Care Testing
- Polytrauma

The facilities reported accomplishment's were training to improve staff awareness of and increase referrals to the Ethics Consult Service and development of a process to capture utilization management physician advisor recommendations and actions taken by attending physicians.

Recommendations: We made recommendations in the following three activities:

Environment of Care: Ensure that Safety and Environment of Care Committee minutes reflect sufficient analysis of rounds findings and reflect actions taken on identified deficiencies and that reports and relevant results are communicated to service line chiefs and committee members. Require Infection Control Committee minutes to include sufficient data analysis, risk identification, and corrective actions taken. Ensure emergency department patient care areas are clean. Require Material Safety Data Sheet information in the emergency department to be accessible.

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Require that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Quality Management: Ensure that Focused Professional Practice Evaluations are completed for all newly hired licensed individual practitioners and that results are consistently reported to the Medical Executive Committee.

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.

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care 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

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 nine activities:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through April 13, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Beckley VA Medical Center, Beckley, West Virginia,* Report No. 10-02383-27, November 10, 2010).

During this review, we also presented crime awareness briefings for 133 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 97 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

Integrated Ethics

In February 2011, members of the facility's Ethics Consultation Team began conducting rounds in clinical and non-clinical areas to publicize the ethics consult services. The rounds resulted in enhancements to the Ethics Consult Service, including the establishment of an ad-hoc team to address business-related ethical issues; an increase in the number of ethics consults in FY 2011; and an expansion of ethics consult requestors from physicians to other disciplines, such as clerks and nurses, and to patients' family members. In order to further encourage staff to forward ethics-related questions and concerns, the facility plans to continue staff education on the Ethics Consult Service through presentations at staff meetings.

UM Physician Advisor Reviews

In 2010, the revised UM directive mandated documentation of PUMA engagement and clinical recommendations as well as communication with the attending physicians and subsequent follow-through of the recommendations.

In FY 2012, the facility began using an enhanced reporting section of the National UM Interface Package to display PUMA-reviewed cases for the given period of review. The PUMA provides agreement or disagreement with UM reviewer findings and can add additional information in the comments section of the report. UM staff conduct chart reviews using this information to ensure that PUMA recommendations are followed in a timely manner. If the recommendation is not followed, the chart is reviewed for clinical information to justify the patient's continued treatment at the current level of care. Data

from the National UM Interface report and information retrieved during the chart reviews is included in the locally developed quarterly outcome report. This report provides documentation and evidence of clear linkage between the PUMA's recommendation(s) and the follow-through by the attending physician(s). Additionally, this report allows the facility to analyze trends and patterns related to admissions and continued stays and to make data-driven decisions regarding service provision and bed availability.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the ED; the primary care, urology, general surgery, mental health, spinal cord injury, and dental clinics; the community living centers; and the inpatient medical, surgical, and intensive care units. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
X	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
X	Patient care areas were clean.
	Fire safety requirements were met.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General IC practice requirements in the dental clinic were met.
	Dental clinic IC process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.

Noncompliant	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program (continued)
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Meeting Minutes. The JC requires the facility to monitor and analyze EOC issues and to take action on identified deficiencies until resolved. Local policy requires relevant results to be communicated and committee minutes to be submitted to committee members and service line chiefs. We reviewed monthly Safety and EOC Committee minutes for July through December 2011 and determined that they did not sufficiently reflect analysis of findings from EOC rounds or reflect that actions were taken on identified deficiencies until resolved. Additionally, reports were not submitted and relevant results and recommendations were not communicated to service line chiefs and committee members.

The JC requires the facility to identify risks for acquiring and transmitting infections based on the analysis of surveillance activities and other IC data. We reviewed monthly IC Committee minutes for July through December 2011 and determined that they did not sufficiently reflect data analysis, risk identification, and corrective actions taken.

Cleanliness. The JC requires that areas used by patients are clean. In the ED, we found that portable equipment needed cleaning and that high and low dusting was needed throughout.

Environmental Safety. The Occupational Safety and Health Administration requires Material Safety Data Sheets to be accessible in the areas in which chemicals are used. We found chemicals in the ED for which the Material Safety Data Sheets were not accessible to staff.

Recommendations

1. We recommended that processes be strengthened to ensure that Safety and EOC Committee minutes reflect sufficient analysis of findings from EOC rounds and reflect actions taken on identified deficiencies and that reports and relevant results and recommendations are submitted and communicated to service line chiefs and committee members.

2. We recommended that processes be strengthened to ensure that IC Committee minutes include sufficient data analysis, risk identification, and corrective actions taken.

3. We recommended that processes be strengthened to ensure that ED patient care areas are clean.

4. We recommended that processes be strengthened to ensure that Material Safety Data Sheet information in the ED is accessible.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in Surgery Clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[1] Five patients did not receive a colonoscopy due to personal choice or medical instability, and two patients received a colonoscopy as the screening test (which was also the diagnostic test). Of the remaining 13 patients, 8 did not receive diagnostic testing within the required timeframe.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[2] Of the 15 patients who had a biopsy, 6 EHRs did not contain documented evidence of timely notification.

Recommendations

5. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

6. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2007-004.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed UM reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a PUMA for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPEs. VHA requires that FPPEs be completed for newly hired licensed independent practitioners and that results be reported to the MEC for consideration in making the recommendation on privileges.[3] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that an FPPE was not initiated for 1 practitioner. Additionally, results were not reported to the MEC for three of the nine practitioners who had FPPEs initiated and completed.

Recommendation

7. We recommended that processes be strengthened to ensure that FPPEs are completed for all newly hired licensed independent practitioners and that results are consistently reported to the MEC.

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 29 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[4] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[4] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 10 EHRs, and 2 training/competency records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 22 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 3A for 30 randomly selected days between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of five patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury screening results, and 1 training record, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–25, for the full text of the Directors' comments.) We consider Recommendation 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[5]		
Type of Organization	General medical and surgical care facility that provides primary care, secondary diagnostic and therapeutic specialty services, and long-term care	
Complexity Level	3	
VISN	6	
Community Based Outpatient Clinic	Maxwelton, WV	
Veteran Population in Catchment Area	32,021	
Type and Number of Total Operating Beds: • **Hospital**	40 – 33 medical, 2 surgical, and 5 intensive care	
• **Community Living Center/Nursing Home Care Unit**	50	
• **Other**	0	
Medical School Affiliation(s)	West Virginia School of Osteopathic Medicine	
• **Number of Residents**	1 resident medical student and 1 geriatric fellow position	
	Current FY (through February 1, 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$100	$102
• **Medical Care Expenditures**	$34	$100
Total Medical Care Full-Time Employee Equivalents	746.35	723.74
Workload:		
• **Number of Station Level Unique Patients**	11,301	13,736
• **Inpatient Days of Care:**		
o **Acute Care**	2,390	9,715
o **Community Living Center/Nursing Home Care Unit**	4,563	13,514
Hospital Discharges	462	1,807
Total Average Daily Census (including all bed types)	66	64
Cumulative Occupancy Rate (in percent)	73.3	71.1
Outpatient Visits	66,782	159,031

[5] All data provided by facility management.

VHA Satisfaction Surveys

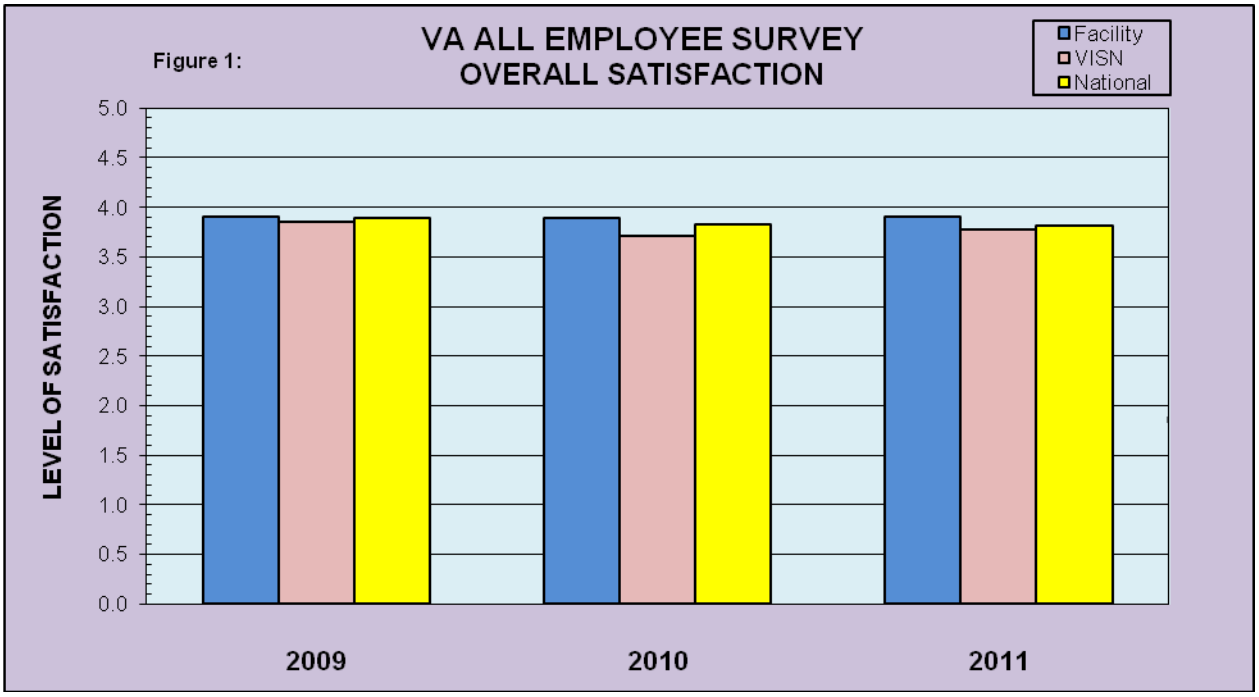
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	63.0	58.7	47.7	47.9	51.9	54.3
VISN	62.8	62.5	50.1	49.5	51.8	48.8
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[6] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[7]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	10.1	10.6	**	22.1	20.2
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

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

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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 8, 2012

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

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

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review on April 16–19, 2012.

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: May 7, 2012

From: Director, Beckley VA Medical Center (517/00)

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

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review on April 16–19, 2012.

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 OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that Safety and EOC Committee minutes reflect sufficient analysis of findings from EOC rounds and reflect actions taken on identified deficiencies and that reports and relevant results and recommendations are submitted and communicated to service line chiefs and committee members.

Concur

Target date for completion: The target date for completion is July 31, 2012.

The Environment of Care (EOC) Committee minute format and applicable data being reported and tracked have been reviewed during a meeting held on April 27, 2012 and the reporting programs have submitted their revised information for the April 2012 EOC meeting. Reporting services have revised and stream lined information reported to the committee ensuring better flow of the information presented and recorded in the minutes. The EOC minutes will be distributed to the committee members for review prior to submission to the Quad for signature. This distribution and review process will occur each month to assure correct data capture, accurate reporting of topics discussed, and tracking of open items and approval of minutes prior to finalization and submission to the Quad for signature. The official signed minutes will be posted on the public drive in the folder titled "Safety Committee" for committee members. Deferred reports and actions requiring follow up will be tracked monthly until the Topic is closed.

The EOC Round recommendations are tracked monthly until completed with a target for closing these items within 14 days of the review. Our performance with this measure is 95.2%. EOC recommendations/findings, identified on a weekly-basis are tracked using an Excel spreadsheet and will be an attachment to the EOC Minutes. This Attachment lists the individual or service line responsible for correcting the EOC rounds recommendation and lists the date it was corrected. Weekly EOC rounds recommendations are also trended to identify issues that are routinely found during our weekly EOC Rounds. These trends are documented and are updated on a monthly-basis and reported to the EOC Committee. The EOC Committee will assure topics are accurately recorded, data is trended and analyzed where appropriate, actions are tracked through closure using the action item tracking log.

Recommendation 2. We recommended that processes be strengthened to ensure that IC Committee minutes include sufficient data analysis, risk identification, and corrective actions taken.

Concur

Target date for completion: The target for completion is July 31, 2012.

The Infection Control stakeholders reviewed the Infection Control Committee minute documentation to strengthen the capture of data analysis, risk identification, and corrective actions taken. To ensure understanding of reporting requirements by committee members, instructions were sent to the members defining a standardized reporting format for reports due to the Infection Control Committee.

On April 27, 2012, a review of MCM 118-A-01, Infection Control Program was completed ensuring that all elements required by policy will be addressed during future IC Committee meetings. To ensure committee members are aware of the month in which reports are due for presentation to the committee, a reporting calendar was distributed on April 27, 2012. To ensure accuracy of agenda items presented, the minutes will be circulated prior to the meeting for review and approval by the committee members.

The Associate Director of Patient Care Services in collaboration with the Chair of the Infection Control Committee will ensure the minutes contain sufficient data analysis, risk identification, and corrective actions taken. Upon completion the minutes forwarded to the Quad for final review and signature. A copy of the signed minutes will be sent to all committee members for their records. A tracking log of all open items will be maintained/updated to ensure that follow up actions are not missed.

Recommendation 3. We recommended that processes be strengthened to ensure that ED patient care areas are clean.

Concur

Target date for completion: The ED Department was thoroughly cleaned as of April 17, 2012. Housekeeping rounds began 5–8–12.

The ED Clinical Care Coordinator (CCC) and the Housekeeping Supervisor, met to reconfirm policy requirements for cleaning the ED.

a. Patient and non-patient rooms will be cleaned daily by housekeeping service. A Housekeeper is staffed in the ED on day shift and evening shift.
b. ED nursing staff cleans the counter surfaces, changes linen and clean all patient equipment between each patient use. Patient equipment is cleaned according to manufacturer's recommendations and established SOPs.
c. To ensure the ED area is cleaned according to FM 15 Environmental Services, the following procedures have been implemented.
    a. The ED Clinical Care Coordinator will make daily rounds to ensure ED is clean and orderly and patient equipment is cleaned properly.

b. The Day shift and night shift triage nurses will make joint rounds to inspect ED patient rooms, non-patient rooms and patient equipment for cleanliness and proper storage and will documents findings using the ED housekeeping rounds form.
c. The ED CCC and Housekeeping Supervisor will make rounds once per week to inspect the ED for cleanliness and to resolve any identified concerns pertaining to ED cleanliness and housekeeping schedules.

Recommendation 4. We recommended that processes be strengthened to ensure that Material Safety Data Sheet information in the ED is accessible.

Concur

Target date for completion: This action was completed May 2, 2012.

In accordance with MCM FM 10 Hazard Communication Program, a Master file is maintained in the Emergency Department (ED). The ED serves to provide employees with 24-hour access to necessary information. Additionally, MSDS access is available online. A copy of the Material Safety Data Sheets (MSDS) for Gebauers's Ethyl Chloride was placed in the ED section of the MSDS books as of May 2, 2012. The shelf which holds the MSDS Manual was lowered on May 2, 2012, to accommodate all medical center employees. The chemical inventory was updated to include Gebauers's Ethyl Chloride and was submitted to the Safety Officer on May 2, 2012. The pharmacy dispenses this chemical to the specialty clinics as well. Upon review of the Specialty Care MSDSs, a hard copy of this MSDS was available and properly filed.

MCM FM 10 Hazardous Communication Program defines procedures to ensure all chemicals and hazardous materials are inventoried is a follows:

a. Each service line maintains current inventories of all chemicals and hazardous materials used and/or stored within the service line areas.
b. The service line inventory is reviewed annually and updated as necessary. The individual inventories maintained by each service line shall be updated as additional chemicals/hazardous materials are received. The Hazard Communication/MSDS Coordinator shall ensure the new chemicals are registered with the Safety Manager.
c. The inventory must be crosschecked with the MSDS file to ensure that a current MSDS from the chemical manufacturer is on file for all hazardous chemicals/materials. The name on the label of the chemical must be identical with the name on the MSDS.
d. The Industrial Hygienist will distribute inventories annually to be verified and returned to the safety office.
e. At the time of the annual inventory, the service line chief or the Hazard Communication/MSDS Coordinator shall perform a physical survey of all hazardous chemicals/materials within the service line. All area locations will be checked for proper storage, labeling, shelf life, and use of hazardous materials.

f. The Hazard Communication/MSDS Coordinator verifies that MSDSs are on file for each chemical before returning the inventory to the safety office. The online database should be utilized. The updated inventory should identify which chemicals were added and deleted.

Recommendation 5. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: The target for completion is August 8, 2012.

As of 5/1/12 the facility has established a proactive approach to strengthen our internal processes to ensure patients receive diagnostic testing within 60 days of positive FOBT screening results:

1. A facility Colorectal Screening Committee was developed. The purpose of this committee is to provide oversight, guidance, and ensure adherence to VHA Directive 2007-004, Colorectal Cancer Screening. This committee will meet monthly.
2. All positive FOBT screenings requiring diagnostic testing will be reviewed by the GI PA who will then schedule these patients into the Operating Room schedule. If the Operating Room schedule does not allow for diagnostic testing within the 60 day timeframe the PA will enter a fee basis consult. All fee basis consults are reviewed and approved through the Chief of Staff
3. To ensure compliance of diagnostic testing within 60 days the FOBT tracking tool will be utilized to monitor the scheduling of colonoscopies for patients referred to the GI clinic for positive FOBT. In addition, fee basis consults are monitored for timeliness and follow up. Monitoring reports and action plans will be presented monthly to the Colorectal Screening Committee and quarterly to the facility Clinical Executive Board. The first quarterly report to the Clinical Executive Board is scheduled to be reported August 8, 2012.

Recommendation 6. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: The target date for completion is August 8, 2012.

Patients receive notification of colonoscopy biopsy results within required timeframe and notification is documented by clinicians.

1. A facility Colorectal Screening Committee was developed. The purpose of this committee is to provide oversight, guidance, and ensure adherence to VHA

Directive 2007-004, Colorectal Cancer Screening. This committee will meet monthly.
2. Pathology services for Beckley VAMC are provided off-site through Richmond VAMC. To ensure timely notification of GI pathology reports the Beckley GI PA provider will be designated as an additional signer on all completed pathology reports for GI services.
3. Within 14 days of receipt and review of completed GI pathology reports the GI PA will notify patients of the pathology results via letter and document notification in the patient record.
4. In the absence of the GI PA a local surrogate will be designated to receive and review GI pathology reports. The surrogate will then notify the patient via letter and document notification in the patient record.
5. To ensure compliance of patient notification of the biopsy results within 14 days the FOBT tracking tool will be utilized. Monitoring reports and action plans will be presented monthly to the Colorectal Screening Committee and quarterly to the facility Clinical Executive Board. The first quarterly report to the Clinical Executive Board is scheduled to be reported August 8, 2012.

Recommendation 7. We recommended that processes be strengthened to ensure that FPPEs are completed for all newly hired licensed independent practitioners and that results are consistently reported to the MEC.

Concur

Target date for completion: The re-designed excel database was implemented May 4, 2012, and is used to track the FPPEs due each month. The result of FPPEs completed by the Professional Standards Board was presented to the Clinical Executive Board on May 9, 2012.

The credentialing coordinator(s) track all Focused Professional Practice Evaluations (and Ongoing Professional Practice Evaluations) by using a re-designed excel database which clearly indicates the due date of the FPPE. Any overdue FPPE will be noted in Professional Standard Board (PSB) minutes (sub-committee of the Medical Executive Committee/Clinical Executive Board) under “Old Business” which will place direct focus on any service lines past due FPPEs. Notification will be issued to the Service Line Medical Director/Chief and Administrative Officer electronically, and the COS will be copied on the email. The overdue item will remain on the Old Business section of PSB minutes until closed. Careful notation of all PPEs sent and received will be noted in PSB minutes in the appropriate section. The Credentialing Coordinators have also issued a “Refresh Your Knowledge” email to all stakeholders of the FPPEs, along with the applicable policy and guidance to ensure those responsible for completing the Professional Practice Evaluation forms (focused or ongoing) have the most current information to complete these documents in a timely manner. The Professional Standard Board reports the results of Focused Professional Practice Evaluations completed monthly to the Medical Executive Committee/Clinical Executive Board.

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