Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00882-232

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

July 27, 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
CLC	community living center
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Martinsburg VA Medical Center
FY	fiscal year
HF	heart failure
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Martinsburg VA Medical Center Martinsburg, 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 2, 2012.

Review Results: The review covered 11 activities. We made no recommendations in the following activity:

- Medication Management

The facility's reported accomplishment was the creation of a quarterly Community Partnership Forum.

Recommendations: We made recommendations in the following 10 activities:

Mental Health Treatment Continuity: Ensure all discharged mental health patients on the high risk for suicide list receive follow-up at the required intervals. Offer mental health services at least one evening per week.

Coordination of Care: Ensure medications ordered at discharge match those listed on discharge instructions. Schedule follow-up appointments within the requested or required timeframes.

Colorectal Cancer Screening: Notify patients of positive screening test results within the required timeframe. Develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Environment of Care: Fix and/or replace damaged floor tiles. Ensure boxes are not stored on the floor.

Moderate Sedation: Ensure staff receive required training prior to assisting with moderate sedation. Include all required elements in pre-sedation assessment documentation.

Point-of-Care Testing: Ensure employees who perform glucose testing have competency assessed annually. Date testing reagents when opened.

Polytrauma: Share outpatient treatment plans with patients and/or the patients' families. Maintain minimum staffing levels.

Nurse Staffing: Ensure all required staff are members of the facility expert panel. Ensure members of the expert panels receive required training.

Quality Management: Consistently monitor the copy and paste functions.

Follow-Up on Reusable Medical Equipment Competencies: Ensure that managers validate competencies annually for staff who reprocess equipment and that competencies are documented.

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 11 activities:

- Coordination Of Care
- CRC Screening
- EOC
- Follow-Up on RME Competencies
- Medication Management
- MH Treatment Continuity
- 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 2, 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 Martinsburg VA Medical Center, Martinsburg, West Virginia,* Report No. 10-01619-216, July 28, 2010). We made repeat recommendations in RME competencies.

During this review, we presented crime awareness briefings for 31 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 157 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 Accomplishment

Community Partnership Forum

The facility developed a quarterly Community Partnership Forum to collaborate with community organizations regarding issues that affect veterans. To facilitate participation, access to the forum is available via conference call or video conferencing. State congressional office staff, community partners, and more than 45 Veterans Service Organizations participate. The forum's agenda provides time for updates on One-VA efforts and on the Veterans Benefits Administration and the National Cemetery Administration and for addressing concerns brought by other participants. In addition to problem solving, all members share information on services available through their organizations and on upcoming events. An example of how the forum benefits veterans occurred recently when the topic of discussion for the meeting was moving homeless veterans into Housing and Urban Development/VA Supported Housing and veterans' lack of furniture, toiletries, and other household items. Community partners identified resources to help acquire the items and came up with a plan to donate items to the facility on as needed basis.

Results

Review Activities With Recommendations

MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
X	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Follow-Up for High Risk for Suicide Patients. Through its MH performance measures, VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list receive two outpatient follow-up evaluations within 14 days of discharge and two outpatient follow-up evaluations within days 15–30 from discharge. Nine of the 10 patients discharged who were on the high risk for suicide list did not receive MH follow-up at the required intervals. Eight patients did not receive the required evaluations within 14 days of discharge, and none of the nine patients received the required evaluations within days 15–30 from discharge.

Availability of MH Services. VHA requires that facilities offer MH services at least one evening per week.[1] The facility did not offer evening MH services.

Recommendations

1. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

2. We recommended that the facility offer MH services at least one evening per week.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

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 25 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Discharge Medications. The JC's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In three EHRs, medications ordered at discharge did not match those listed in patient discharge instructions.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[2] Local policy requires that HF patients discharged from an inpatient stay return for an initial follow-up appointment within 7 days of their discharge dates. Although provider discharge instructions requested specific follow-up appointment timeframes, 19 appointments were either not scheduled as requested or were not scheduled within the timeframe required by local policy.

Recommendations

3. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

4. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

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

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 positive CRC screening tests and 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
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	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.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests and that clinician's document notification.[3] Seven patients' EHRs did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[4] Seven patients did not have a documented follow-up plan within the required timeframe.

Recommendations

5. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinician's document notification.

6. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

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

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 and whether the facility's Substance Abuse and Post-Traumatic Stress Disorder RRTPs were in compliance with selected MH RRTP requirements.

We inspected the CLC, psychiatry, intensive care, and inpatient medical-surgical units and the Substance Abuse and Post-Traumatic Stress Disorder RRTPs. We also inspected the emergency department and primary care and the women's health, MH, dental, and SCI clinics. 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
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	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 infection control practice requirements in the dental clinic were met.
	Dental clinic infection control 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 MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.

Noncompliant	Areas Reviewed for MH RRTP (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.

Environmental Safety. The JC requires the facility to establish and maintain a safe, functional environment. We observed damaged floor tiles that presented tripping hazards in corridors leading to the MH RRTP[5] and the emergency department.

Infection Prevention. Facility policy states that corrugated boxes should be removed or placed on pallets. In two supply rooms, we found corrugated boxes stored on the floor.

7. We recommended that the damaged floor tiles be fixed and/or replaced.

8. We recommended that processes be strengthened to ensure that boxes are not stored on the floor and that compliance be monitored.

[5] The Substance Abuse and Post-Traumatic Stress Disorder RRTPs are located off the same corridor.

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, 6 EHRs, and 80 training/competency records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	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.

Competency-Based Education/Training. VHA requires that staff and providers have the education, training, and competency to provide moderate sedation.[6] Local policy requires that staff complete annual competency-based education/training. Twelve staff training records did not contain documentation of receipt of annual competency-based education/training prior to assisting with moderate sedation.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[7] Five patients' EHRs did not include all required elements of the history and physical examination, such as a review of substance use and abuse.

Recommendations

9. We recommended that processes be strengthened to ensure that staff receive annual competency-based education/training prior to assisting with moderate sedation.

10. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[6] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[7] VHA Directive 2006-023.

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, 31 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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.
X	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.
X	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.

Competency Assessment. VHA requires the facility to complete and document competency assessments for all employees who perform glucose POCT.[8] The College of American Pathologists requires that after successful initial competency assessment and 6-month reassessment, all employees who perform glucose POCT must then have competency assessed annually. Seven of the employee training and competency records did not have documented evidence of annual competency assessment.

Quality Control. VHA requires that the facility follow the manufacturers' recommendations for performing the testing.[9] This includes recommendations for

[8] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
[9] VHA Handbook 1106.01.

quality control, reagent storage, maintenance, and function checks. In one of the patient care areas, reagents were not dated when opened.

Recommendations

11. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed annually.

12. We recommended that processes be strengthened to ensure that testing reagents are dated when opened.

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 results, 7 EHRs of patients receiving traumatic brain injury outpatient services, and 5 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	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.

Outpatient Treatment Plans. VHA requires that the treatment plan developed by the interdisciplinary polytrauma team be shared with patient and, as warranted, the patient's family.[10] Six of the seven outpatient EHRs did not include documentation that the plan had been shared with the patient and/or the patient's family.

Staffing. VHA requires that minimum polytrauma staffing levels be maintained.[11] The facility did not have a rehabilitation nurse, social worker, or psychologist assigned to the program.

[10] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[11] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

13. We recommended that processes be strengthened to ensure that outpatient treatment plans are shared with the patient and, as warranted, the patient's family and that this is documented in the EHR.

14. We recommended that minimum polytrauma staffing levels be maintained.

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 interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (4A) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
X	The facility expert panel followed the required processes.
X	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.

Facility Expert Panel Composition. VHA requires that expert panels are comprised of staff knowledgeable about the facility and able to make staffing judgments.[12] The facility's expert panel did not include all required members, such as staff nurses or other nursing staff providing direct patient care or Associate or Assistant Nurse Executives with clinical area responsibilities.

Expert Panel Member Training. VHA requires that all members of the facility and unit-based expert panels complete chapter 1 of the Staffing Methodology National Training.[13] We did not find documentation that any of the facility or unit-based expert panel members had the required training.

15. We recommended that the annual staffing plan reassessment process ensure that all required staff are members of the facility expert panel.

16. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

[12] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
[13] VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, 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.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor 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 a medical record 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.
X	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.

Copy and Paste Function Monitoring. VHA requires facilities to monitor the copy and paste functions in the EHR.[14] Facility policy requires monthly monitoring and reporting of results to the Patient Record Committee. We reviewed committee meeting minutes for the period March 2011–February 2012 and did not find evidence of copy and paste function monitoring for the period May 2011–January 2012. The facility resumed monitoring the copy and paste functions in February 2012.

17. We recommended that processes be strengthened to ensure that the copy and paste functions are consistently monitored.

[14] VHA Handbook 1907.01.

Review Activity With Previous CAP Recommendations

Follow-Up on RME Competencies

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with competency validation for employees who reprocess RME.

Competencies. VHA requires annual competency validation for employees who reprocess RME.[15] We reviewed the competency folders for the three Central Instrument Processing employees who reprocess bronchoscopes, colonoscopes, and transesophageal probes. We found that none of the employees had current annual competencies for the bronchoscope and colonoscope. In addition, two employees lacked annual competency for the transesophageal probe.

18. We recommended that processes be strengthened to ensure that managers validate competencies annually for staff who reprocess RME and that competencies are documented.

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

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[16] 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.
	Clinicians appropriately monitored patients started on methadone or 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.

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

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 22–30, for the full text of the Directors' comments.) We consider Recommendations 4, 9, 12, and 18 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[17]		
Type of Organization	Level II facility; VA medical center	
Complexity Level	2	
VISN	5	
Community Based Outpatient Clinics	VA staffed: Cumberland, MD; Ft. Detrick, MD; Hagerstown, MD; Stephens City, VA VA contract: Harrisonburg, VA; Franklin, WV; Petersburg, WV	
Veteran Population in Catchment Area	138,235	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	Acute – 71; Domiciliary – 312	
• **CLC/Nursing Home Care Unit**	121	
• **Other**	Compensated Work Therapy Transitional Housing – 8	
Medical School Affiliations	West Virginia University Schools of Medicine and Dental Medicine George Washington University School of Medicine and Health Sciences West Virginia School of Osteopathic Medicine	
• **Number of Residents**	33	
	Current FY (through January 2012 except where noted)	**Prior FY (2011)**
(Fiscal) Resources (in millions):		
• **Total Medical Care Budget**	$229	$258
• **Medical Care Expenditures**	$5.7 (through December 2011)	$258
Total Medical Care Full-Time Employee Equivalents	1,520	1,565
Workload:		
• **Number of Station Level Unique Patients**	22,863	33,467
• **Inpatient Days of Care:**		
o **Acute Care**	3,776	17,776
o **CLC/Nursing Home Care Unit**	9,857	42,067
Hospital Discharges	752	3,245
Total Average Daily Census (including all bed types)	451.4	459.0
Cumulative Occupancy Rate (in percent)	89	90
Outpatient Visits	111,082	435,314

[17] All data provided by facility management.

VHA Satisfaction Surveys

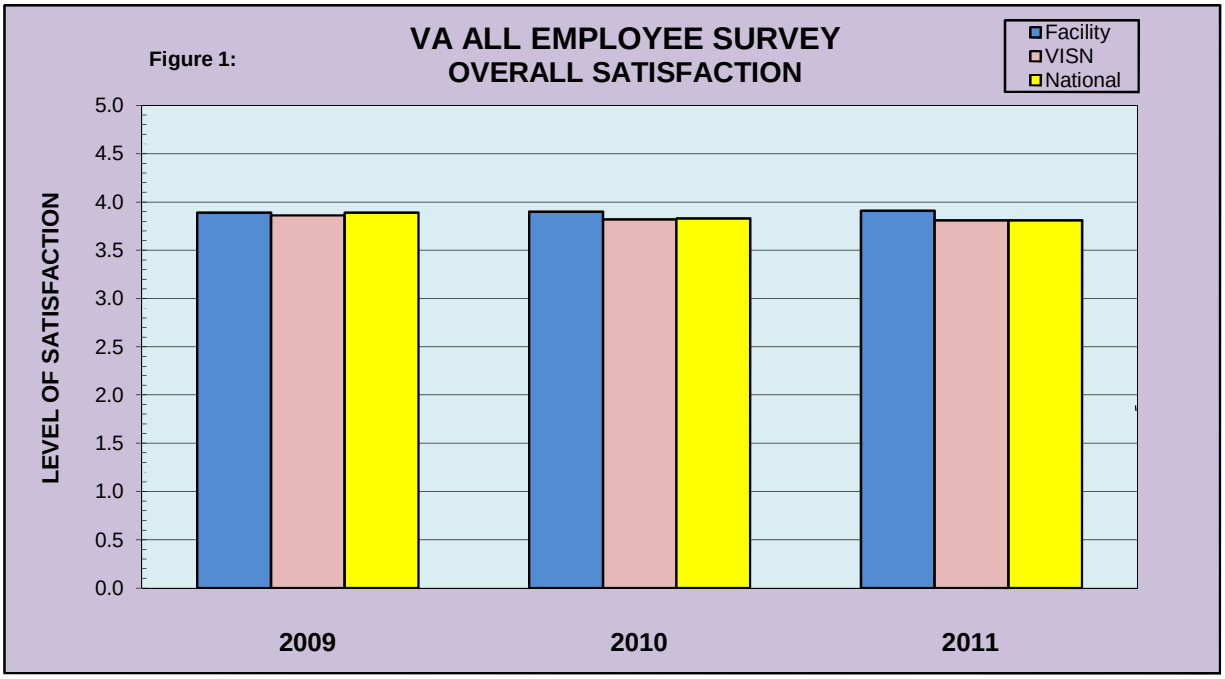
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

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	65.4	66.9	60.0	62.8	64.0	57.6
VISN	57.2	60.8	57.1	61.3	52.9	51.0
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.[18] 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.[19]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	*	10.1	10.5	20.1	25.3	15.8
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

* No data was available from the facility for this measure.

[18] 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.

[19] 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: June 29, 2012

From: Director, VA Capitol Health Care Network (10N5)

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

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

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

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

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

(original signed by:)
Fernando O. Rivera, FACHE
Director, VA Capitol Health Care Network
VISN 5

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2012

From: Director, Martinsburg VA Medical Center (613/00)

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

To: Director, VA Capitol Health Care Network (10N5)

1. Thank you for allowing me to respond to this OIG CAP Review of Martinsburg VA Medical Center, Martinsburg, WV. We found the review educational and helpful. We appreciate the professionalism demonstrated by the OIG CAP Team.
2. Attached please find the Martinsburg responses and relevant actions for the 18 recommendations from the Office of the Inspector General CAP review conducted the week of April 2, 2012.
3. If you have any questions regarding this report please contact V. Denise O'Dell, RN, MSA, CPHQ, Chief Quality Management, Martinsburg VAMC, at (304) 263-0811, extension 4035.

(original signed by:)
Ann R. Brown, FACHE

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 all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance be monitored.

Concur

Target date for completion: June 22, 2012

Facility's response: The High Risk for Suicide information obtained from VSSC details report are updated weekly. The medical center obtains the most recent information by manual medical record review (not a pull of stop codes as VSSC does). High Risk for Suicide patients are flagged by suicide prevention staff when a patient makes a recent (within the last 90 days) suicide attempt. We have a few Veterans that were flagged as a precautionary measure. Those Veterans have not made an attempt but are at increased risk because of their specific current circumstances. Flags are reviewed every 90 days and are either inactivated or continued based on recommendations of the flag review committee which includes the suicide prevention staff.

The Suicide Prevention Coordinators are monitoring and tracking the 0–14 and 15–30 day follow up for all High Risk for Suicide patients who are newly flagged and those flagged patients who are discharged from inpatient status (both of these will start the four week follow up measure). Our goal is to complete the 0–14 and 15–30 day follow up process and monitoring as VHA outlined and as instructed by VISN 5 for flagged high risk for suicide patients. Results are verbally reported daily to Medical Center (MC) Leadership in the MC Director's Morning Report. In addition, the VSSC High Risk Suicide Patient Detail report is shared with the VISN. This same report will also be shared with the MC Mental Health Executive Council beginning August 2012.

Recommendation 2. We recommended that the facility offer MH services at least one evening per week.

Concur

Target date for completion: August 15, 2012

Facility's response: Currently Mental Health (MH) services are being provided by a psychologist during evening hours four days a week until 6:30 pm. Morning hours are available at 7 am. Additional evening hours are available to MH patients upon request.

A vacancy announcement for a full time psychiatrist was posted on May 23, 2012. We made a tentative offer to one candidate, and we have begun the pre-employment clearances. This psychiatrist's tour of duty will include evening hours at least once a week. This provider is expected to be on duty by August 15, 2012.

Recommendation 3. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target date for completion: September 28, 2012

Facility's response: At Service Staff meetings the Clinical Service Chiefs will stress to providers to have the discharge medications ordered match the patient discharge instructions list. Additional provider education will be provided as the need is identified. In addition, this reminder has been placed as a standing agenda item for the quarterly Medical Staff meetings.

Compliance is being monitored by Clinical Services via Clinical Pertinence Reviews which are reported to Executive Committee of the Medical Staff.

Recommendation 4. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

Concur

Target date for completion: Completed

Facility's response: Effective May, 2011 a Heart Failure (HF) Clinic was implemented. By doing so all Heart Failure patients discharged from an inpatient stay now return for their initial follow-up appointment within 14 days of discharge. Our Standard Operating Procedure (SOP) was also changed from 7 to 14 days for the initial follow up appointment. This initial HF clinic follow-up is also placed on the patients' discharge instructions which are reviewed with the patient.

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinician's document notification.

Concur

Target date for completion: September 30, 2012

Facility's response: At time of review, the medical center proactively implemented a revised process. That process change was to have Primary Care Providers receive and review the lab reports indicating positive Fecal Occult Blood Test (FOBT) results on a weekly basis.

A team has been established to address this issue. Specifically, the team has been tasked to review the overall process of FOBT/Colorectal Cancer screening to include notification to the patients within the required 14 calendar day timeframe of receiving the results.

The team outcomes will be reported to the MC Quality Council and Executive Committee of the Medical Staff.

Recommendation 6. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: September 30, 2012

Facility's response: At time of review, the medical center proactively implemented a revised process. That process change was to have Primary Care Providers receive and review the lab reports indicating positive Fecal Occult Blood Test (FOBT) results on a weekly basis; then the treatment plan of the patient is being documented in the medical record by the Primary Care Provider.

A team has been established to address this issue. Specifically, the team has been tasked to review the overall process of FOBT/Colorectal Cancer screening to include a well documented plan of action in the medical record by the Primary Care Provider, as appropriate.

The team outcomes will be reported to the MC Quality Council and Executive Committee of the Medical Staff.

Recommendation 7. We recommended that the damaged floor tiles be fixed and/or replaced.

Concur

Target date for completion: July 31, 2012

Facility's response: Facility Management Chief has finalized the work scope development for abatement and tile replacement. The contract has been awarded to Asbestos Indefinite Delivery Indefinite Quantity (IDIQ). IDIQ will be utilized for the abatement and tile replacement which is expected to be completed by July 31, 2012.

Recommendation 8. We recommended that processes be strengthened to ensure that boxes are not stored on the floor and that compliance be monitored.

Concur

Target date for completion: August 23, 2012

Facility's response: The Environment of Care (EOC) Rounds Team inspects each area of the hospital at least twice a year. Checking for boxes on the floor is part of the Environment of Care Rounds Checklist review and this practice will continue. The Environment of Care Rounds team members provide staff education in areas where boxes are found on the floor. June 29, 2012 the Service Safety Representatives received training on the Environment of Care Rounds checklist that are to be utilized in their areas monthly. This training included looking for boxes on the floor. Each Service Safety Representative reviews their area monthly.

The findings are shared with the Service Chief and then included in the EOC Rounds report to the MC Environment of Care Council.

Recommendation 9. We recommended that processes be strengthened to ensure that staff receive annual competency-based education/training prior to assisting with moderate sedation.

Concur

Target date for completion: Completed

Facility's response: All moderate sedation training and competencies have been completed. This training will be added to the Intensive Care Unit (ICU) nurses' annual mandatory training requirements, recorded in the Talent Management System (TMS) and competency assessed annually by the ICU nurse manager.

Recommendation 10. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: August 31, 2012

Facility's response: Quality Management (QM) and Clinical Informatics staff are working to identify the pre-sedation assessment template and current users. Then the pre-sedation template assessments will be reviewed for substance use and/or abuse evaluation and added as needed.

A 30 and 60 day random review of pre-sedation assessments will be performed by QM staff and the results reported to MC Quality Council and Surgical Invasive Procedure Review Committee.

Recommendation 11. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed annually.

Concur

Target date for completion: August 24, 2012

Facility's response: Annual training and competency are now being recorded in the Talent Management System for each employee. The annual employee competency flow sheet is utilized for the annual review and reporting. The goal is for annual training to be at 100% by August 24, 2012. Progress will be monitored until 100% is achieved.

Recommendation 12. We recommended that processes be strengthened to ensure that testing reagents are dated when opened.

Concur

Target date for completion: Completed

Facility's response: This process is now being monitored monthly in each area that utilizes glucose testing reagents with at standardized monitoring tool. The results are sent to QM for analysis of trends and then shared monthly with nursing leadership.

Recommendation 13. We recommended that processes be strengthened to ensure that outpatient treatment plans are shared with patient and, as warranted, the patient's family, and that this is documented in the EHR.

Concur

Target date for completion: July 31, 2012

Facility's response: The Polytrauma Interdisciplinary Care Plan template has been revised to include a space to document that education regarding the plan was provided to the patient and/or family. The Polytrauma team is being educated on template revisions which will be entered into TMS. Only one Polytrauma team member still needs to be trained and that will be completed by July 31, 2012.

Recommendation 14. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: September 17, 2012

Facility's response: Per the Rehabilitation Planning Specialist at VHA Central Office, having a Certified Rehabilitation Registered Nurse (CRRN) as part of the Polytrauma Support Clinic Team (PSCT) is only required for the Polytrauma Rehabilitation Centers and not for lower levels of the Polytrauma System of Care (Polytrauma Network Sites, Polytrauma Support Clinic Team, and Polytrauma Point of Contacts), such as Martinsburg. The RN assigned to the PSCT has completed the TMS Traumatic Brain Injury/VHI: Traumatic Brain Injury training and exam as well as other TBI/Polytrauma training.

The Primary Care Team Social Workers get the Polytrauma referrals. Those same social workers participate in the Polytrauma Interdisciplinary Teams (IDT) meetings via teleconferencing when their physical presence is not possible.

A vacancy for a psychologist was posted and a candidate selected and an offer made. This psychologist will be assigned to the PSCT as a portion of their responsibilities. This newly hired staff's expected start date is August 21, 2012, with patient care beginning in September 2012. In the interim care is being provided by a facility psychologist.

Recommendation 15. We recommended that the annual staffing plan reassessment process ensure that all required staff are members of the facility expert panel.

Concur

Target date for completion: September 17, 2012

Facility's response: Additional members have been identified to serve on the facility expert panel. Their training is being planned and then they will participate in the annual staffing plan reassessment.

Recommendation 16. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: September 17, 2012

Facility's response: The Staffing Methodology Training Course has been placed in the Talent Management System for completion and recording of staff panel members. At present 83% of the designated panel staff have completed the training.

Recommendation 17. We recommended that processes be strengthened to ensure that the copy and paste functions are consistently monitored.

Concur

Target date for completion: July 31, 2012

Facility's response: The copy and paste functions are now being consistently monitored and reported to the Patient Record Committee. The Patient Record Committee meeting minutes indicate the re-establishment of auditing copy and paste functions and the monitoring results.

Recommendation 18. We recommended that processes be strengthened to ensure that managers validate competencies annually for staff who reprocess RME and that competencies are documented.

Concur

Target date for completion: Completed

Facility's response: The one employee's annual competency was signed and provided during the review. The annual education and competency had been completed but lacked the employee's signature which was completed during the CAP review. A revised process to maintain annual competencies for two years was put in place at the time of the review. Competency topics are being placed in the Talent Management System for timely notification and recording purposes.

OIG Contact and Staff Acknowledgments

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