Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00687-155

Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

May 20, 2014

Washington, DC 20420

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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	W.G. (Bill) Hefner VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
NA	not applicable
NM	not met
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of March 24, 2014.

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

- Medication Management
- Coordination of Care

The facility's reported accomplishments were implementing a robotic surgery system and creating a Long-Term Care Center of Excellence.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure the Surgical Work Group meets monthly. Review all surgical deaths. Review the quality of entries in the electronic health record at least quarterly. Ensure the Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings. Implement the plan to track Ongoing Professional Practice Evaluations and present them to the Professional Standards Board within the timeframe required by local policy.

Environment of Care: Ensure all required staff receive training on identification and correction of environmental hazards, proper use of the Mental Health Environment of Care Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units. Require that locked mental health unit panic alarm testing includes VA Police response time and that the locked mental health units' seclusion room floors have a cushioned surface.

Nurse Staffing: Monitor the staffing methodology implemented in October 2013.

Pressure Ulcer Prevention and Management: Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Community Living Center Resident Independence and Dignity: Ensure all care planned/ordered assistive eating devices are provided to residents for use during meals.

Construction Safety: Ensure construction site inspection documentation includes the time of the inspection and the time when corrective actions occurred. Conduct infection surveillance activities related to construction projects, and document this in Infection Control Committee minutes.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 22–28, for the full text of the Directors' comments.) 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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2012, FY 2013, and FY 2014 through March 27, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina,* Report No. 08-03078-44, December 9, 2009). We made a repeat recommendation related to MH EOC training.

During this review, we presented crime awareness briefings for 93 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 416 responded. We shared summarized 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

Robotic Surgery System

In November 2012, the facility became 1 of 3 VISN 6 facilities approved to perform robotic surgery. The robotic surgery system provides surgeons the ability to perform complex procedures through small surgical incisions and supports collaboration between surgeons. The goal of the robotic surgery system is to train surgeons to perform procedures safely and effectively and to reduce complications and improve surgical outcomes. Since the March 2013 initiation, the facility has increased the number of robotic radical prostatectomies,[a] while reducing hospital length of stay and post-operative complications by 50 percent and patients' estimated blood loss by 80 percent.

Hospice and CLC Renovations

In November 2010, the facility initiated a 3-phase minor capital improvement project to create a Long-Term Care Center of Excellence. Phase 1 has been completed and involved renovating the hospice unit to include 12 beds with private rooms and bathrooms; a 6 room/12 bed temporary lodging option for veterans; and a Main Street concept in the atrium of the CLC with various shops, activities, a 24-hour theatre, a town hall, and a barbershop. These improvements create a sense of comfort and familiarity and a community environment within the CLC.

[a] A radical prostatectomy is an operation to remove the prostate gland and some of the tissue around it. It is done to remove prostate cancer.

Results and Recommendations

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 met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 5 times over the past 7 months. Several surgical deaths occurred from July through December 2013: • There was no evidence that some of the deaths were reviewed.
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Five sets of Blood Usage Review Committee meeting minutes reviewed: • Clinical representatives from Surgery and Anesthesia Services only attended three meetings, and a clinical representative from Medicine Service only attended one meeting.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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.	
X	The facility met any additional elements required by VHA or local policy.	In response to a hotline allegation that the facility was expediting delinquent OPPEs prior to our visit, we reviewed the OPPE process. Local policy requires OPPEs to be completed and reported to the Professional Standards Board every 6 months. We found that the tracking process was flawed and that OPPEs were not completed or reported timely. Between February 4 and March 26, 2014, the facility eliminated the backlog of 131 OPPEs and provided a plan to ensure better tracking and timely reporting.

Recommendations

1. We recommended that the Surgical Work Group meet monthly.

2. We recommended that processes be strengthened to ensure that all surgical deaths are reviewed.

3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings.

5. We recommended that the facility implement their plan to track OPPEs and present them to the Professional Standards Board within the timeframe required by local policy and that compliance be monitored.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected medical/surgical unit 2-3, intensive care unit 2-3, CLC unit 42-2C, the emergency department, the primary care clinic Green Team, the podiatry clinic, x-ray and fluoroscopy, and acute MH units 4-3A and 4-3B. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training records (10 radiology employees, 9 acute MH unit employees, 5 MSIT members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
X	MH unit staff, MSIT members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	• One of the MSIT members and all five of the occasional locked MH unit workers had not completed training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units. This was a repeat finding from the previous CAP review.

NM	Areas Reviewed for Acute MH (continued)	Findings
X	The locked MH units were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• Although panic alarm testing was conducted, VA Police response time was not documented for the past 2 months. • Seclusion room floors did not have a cushioned surface.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that all MSIT members and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing documentation includes VA Police response time.

8. We recommended that the locked MH units' seclusion room floors have a cushioned surface.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 22 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 24 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 2-3, CLC unit 42-C, and MH unit 4-3A—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation was not completed until October 25, 2013.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The 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 VHA or local policy.	

Recommendation

9. We recommended that nursing managers monitor the staffing methodology implemented in October 2013.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 21 EHRs of patients with pressure ulcers (8 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 6 of the 21 EHRs, documentation of location, stage, risk scale score, and/or date acquired varied.
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 5 of the applicable 14 patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 20 EHRs of residents (10 residents receiving restorative nursing services and 10 residents not receiving restorative nursing services but candidates for services). We also observed 8 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
X	Care planned/ordered assistive eating devices were provided to residents at meal times.	• Two of 15 assistive eating devices care planned/ordered were not provided to residents at meal time.

	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the B2 emergency department holding room and bathroom renovation. Additionally, we reviewed relevant documents and 10 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • We did not find documented evidence of the time of the inspection and the time when corrective actions occurred.
X	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	Infection Control Committee minutes for past 2 quarters reviewed: • There was inconsistent documentation of infection surveillance activities related to the project.
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

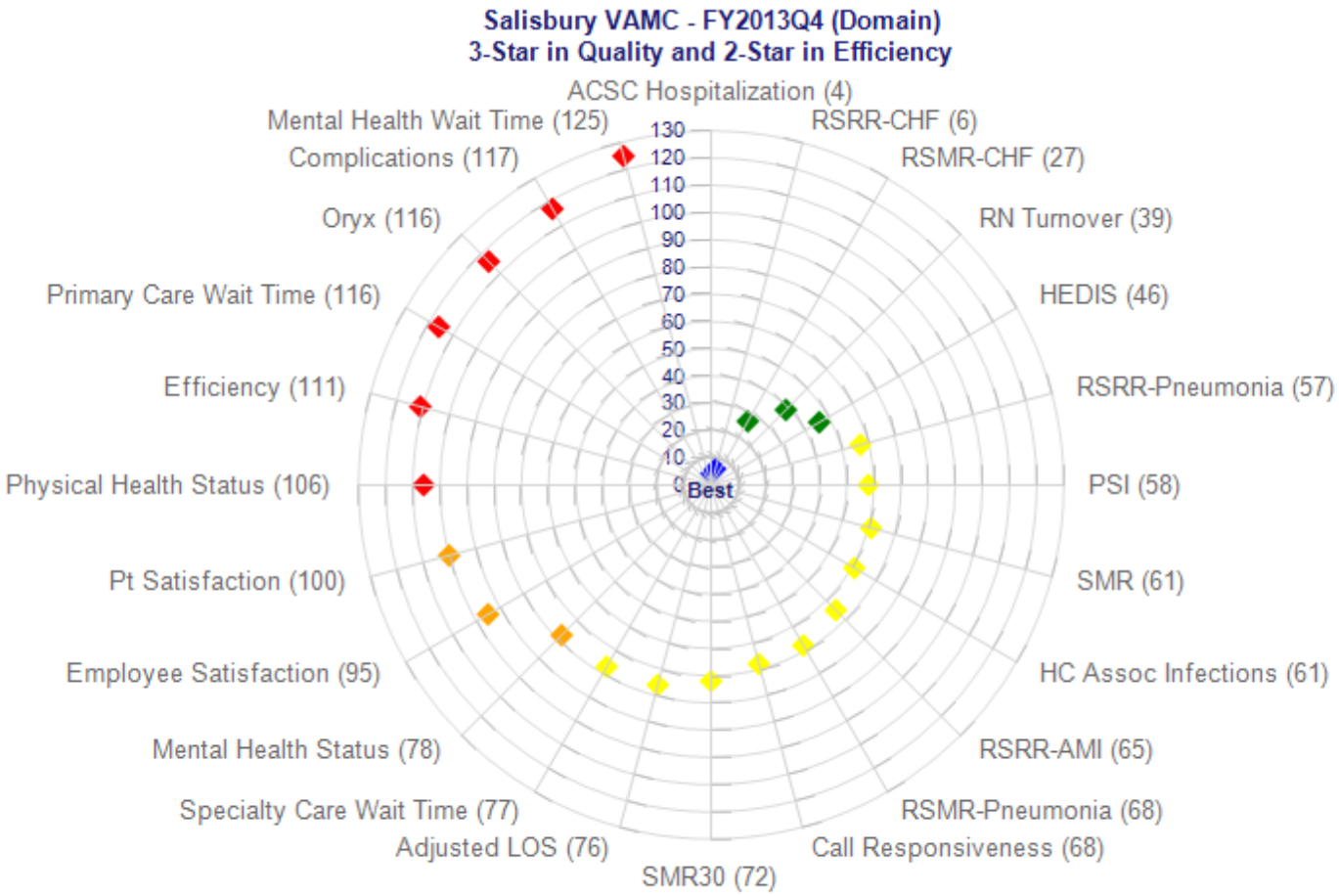
13. We recommended that processes be strengthened to ensure that inspection documentation includes the time of the inspection and the time when corrective actions occurred.

14. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are consistently conducted and documented in Infection Control Committee minutes.

Facility Profile (Salisbury/659) FY 2014 through March 2014[b]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$372.9
Number of:	
• **Unique Patients**	68,678
• **Outpatient Visits**	405,584
• **Unique Employees**[c]	2,002
Type and Number of Operating Beds (February 2014):	
• **Hospital**	107
• **CLC**	270
• **MH**	35
Average Daily Census:	
• **Hospital**	75
• **CLC**	105
• **MH**	26
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Winston-Salem/659BY Charlotte/659GA Hickory/659GB
VISN Number	6

[b] All data is for FY 2014 through March 2014 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

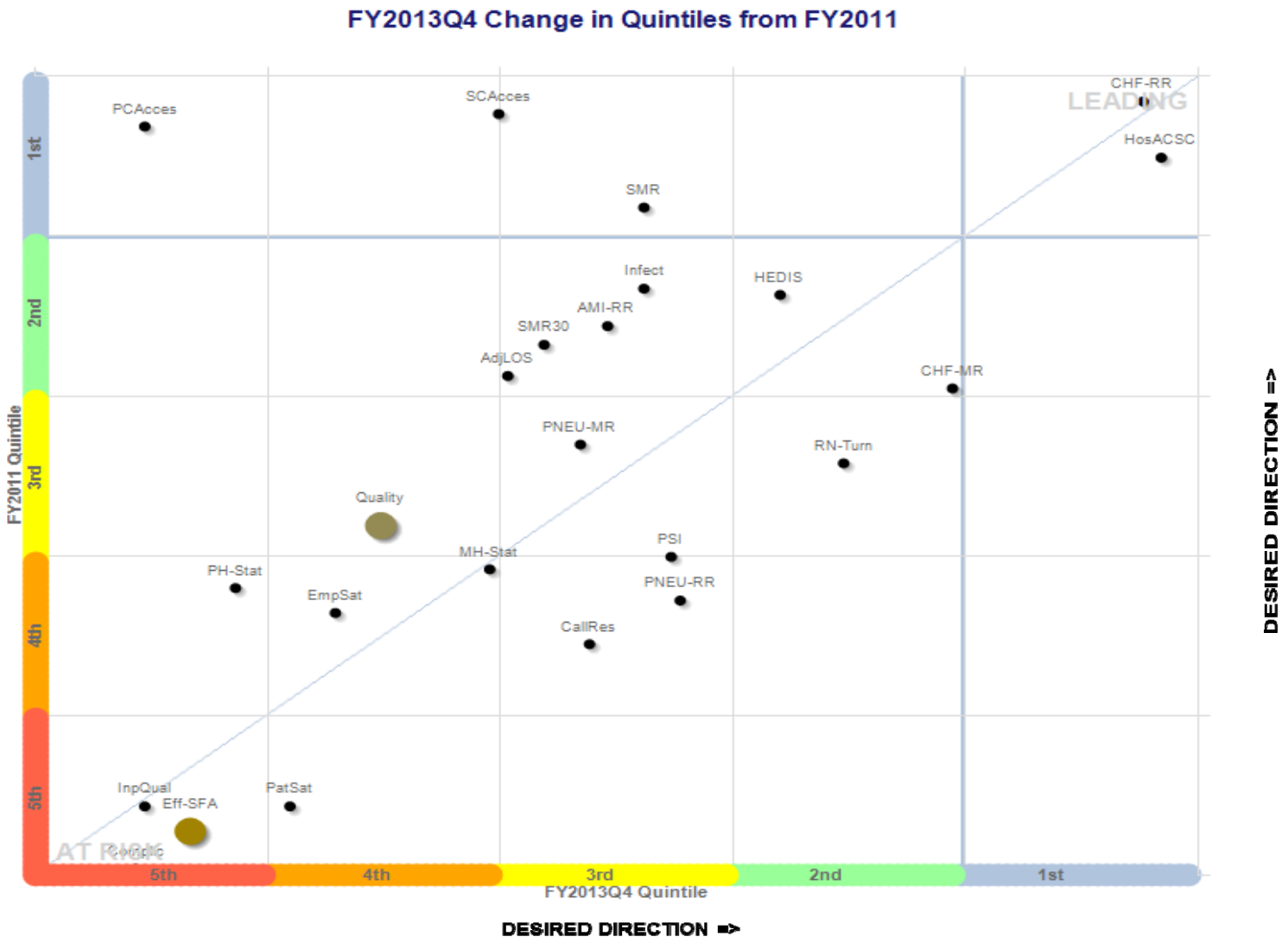
Strategic Analytics for Improvement and Learning (SAIL)[d]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[d] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 29, 2014

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

Subject: **CAP Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, NC**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the W. G. (Bill) Hefner VA Medical Center (VAMC), Salisbury, NC, and concur with the facility's recommendations.

2. If you have further questions, please contact Lisa Shear, VISN 6 QMO, at (919) 956-5541.

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

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 28, 2014

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

Subject: **CAP Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, NC**

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

1. I have reviewed the draft report of the Office of Inspector General and I concur with the recommendations.
2. I have included my response in the attached Director's Comments.
3. Please contact me if you have any questions or comments.

(original signed by:)
KAYE GREEN, 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 the Surgical Work Group meet monthly.

Concur

Target date for completion: Completed

Facility response: The surgical work group has been meeting monthly as required since September 2013. The minutes will be reported monthly to the CEB until closure by the OIG and then revert to a quarterly frequency.

Recommendation 2. We recommended that processes be strengthened to ensure that all surgical deaths are reviewed.

Concur

Target date for completion: Completed April 22, 2014

Facility response: The 5 cases not included in the mortality and morbidity conferences were reviewed and included in the April 22, 2014 Surgical Work Group minutes. The VASQIP nurse will monitor monthly surgical work group minutes to ensure that there is documentation that all surgical deaths were assessed in a mortality and morbidity conference. This monitor will be reported to CEB monthly for oversight.

Recommendation 3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

Concur

Target date for completion: Completed

Facility response: Medical Records Committee has developed a reporting matrix for review of the quality of entries in the EHR. This matrix includes all services with staff who document in the EHR. Reviews are scheduled for each quarter to ensure data is collected and analyzed at least quarterly. Compliance will be monitored monthly and reported to CEB until closure by OIG, and then it will revert to a quarterly reporting frequency.

Recommendation 4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: Completed April 9, 2014

Facility response: Members were notified of the attendance requirement. Representatives from all three departments attended the Blood Utilization Review meeting on April 9, 2014. Committee attendance will be monitored monthly until OIG closure to ensure anesthesia, surgery and medicine representatives are present at the meeting. Monthly reports will be provided to CEB for ongoing oversight.

Recommendation 5. We recommended that the facility implement their plan to track OPPEs and present them to the Professional Standards Board within the timeframe required by local policy and that compliance be monitored.

Concur

Target date for completion: Completed March 26, 2014

Facility response: A process using electronic software, Privplus, has been implemented to track OPPEs and send notices prior to their due date to ensure OPPEs are completed timely. There were no overdue OPPEs as of March 26, 2014. Compliance will be monitored and reported monthly to the CEB for ongoing oversight.

Recommendation 6. We recommended that processes be strengthened to ensure that all MSIT members and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: June 15, 2014

Facility response: All MSIT members and occasional locked MH unit employees will complete mandatory training on how to identify and correct environmental hazards, proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units. Training must be completed by 6/15/14. The education department will monitor compliance with training requirements. Compliance will be reported to CEB and ELB for ongoing oversight.

Recommendation 7. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing documentation includes VA Police response time.

Concur

Target date for completion: May 30, 2014

Facility response: The police dispatchers will begin tracking response times to panic alarms in the locked mental health units beginning May 1, 2014. This will be reported monthly to the Environment of Care Committee beginning June 2014. In addition, two response drills are conducted annually and the response times are tracked. These will be reported to the Environment of Care Committee.

Recommendation 8. We recommended that the locked MH units' seclusion rooms have a cushioned surface.

Concur

Target date for completion: June 30, 2014

Facility response: The locked mental health units are scheduled to move to a new building on June 30, 2014. The seclusion rooms in the new building have a cushioned surface. In the interim, padded mats will be placed in the current seclusion rooms and patients continuously observed.

Recommendation 9. We recommended that nursing managers monitor the staffing methodology implemented in October 2013.

Concur

Target date for completion: Completed and Ongoing

Facility response: Staffing methodology was fully implemented in October 2013. Staffing methodology will be monitored and reported to the Nurse Executive Council monthly until OIG closure and then will continue to be monitored as per VHA Directive 2010-034.

Recommendation 10. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: May 30, 2014

Facility response: The Acute Care Wound Care Specialist will train pressure ulcer prevention champions on each shift by April 30, 2014. These Pressure Ulcer

Champions will train front line staff by May 30, 2014, to ensure accurate documentation of location, stage, risk scale score, and date pressure ulcer acquired. The Acute Care Wound Care Specialist will monitor wound care documentation to ensure 90 percent compliance with requirements and will report monthly to Nurse Executive Committee for oversight.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: Completed April 16, 2014

Facility response: Acute Care nursing staff have been reeducated that pressure ulcer prevention education must be given to patients and/or their caregivers. Staff was also educated that the Admission Assessment template in CPRS was revised so to ensure a consistent method for documenting that this education occurred. The revised template was implemented in CPRS on April 16, 2014. The acute care wound care specialist will monitor wound care documentation to ensure it meets 90 percent compliance with patient education documentation requirements. This will be reported monthly to Nurse Executive Committee for oversight.

Recommendation 12. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: May 2, 2014

Facility response: Each tray has a ticket on it with the Resident's Name, Room, Diet, and menu. This ticket has been revised so the need for any adaptive equipment is clearly visible. Food and Nutrition Staff were educated at the April monthly meeting of this change and the need to double check each tray to ensure the proper adaptive equipment is present. The Dietary supervisor will complete at least 30 observations per month to ensure all patients receive ordered adaptive equipment. Compliance will be reported monthly to CEB until closure by the OIG with a target of 90 percent.

Recommendation 13. We recommended that processes be strengthened to ensure that inspection documentation includes the time of the inspection and the time when corrective actions occurred.

Concur

Target date for completion: Complete April 1, 2014

Facility response: Construction Reports format has been revised to include the time of inspection and date when the corrective actions occurred. Reports will be monitored monthly by the Chief of Engineering. Compliance will be reported monthly, until OIG closure, to EOC with a target of 90 percent.

Recommendation 14. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are consistently conducted and documented in Infection Control Committee minutes.

Concur

Target date for completion: April 29, 2014

Facility response: A process has been developed to ensure that infection surveillance activities related to construction projects to ensure that they are consistently conducted. These surveillance activities are scheduled in advance and included on a calendar so all pertinent parties may participate. The Infection Control Committee has a standing agenda item for documentation of surveillance activities of construction projects. The Infection Control Committee meeting minutes will be monitored monthly to ensure documented surveillance of construction projects. Compliance will be reported monthly to EOC for ongoing oversight.

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding–Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[6] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[8] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration regulations.