Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02067-253

Combined Assessment Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina

August 19, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Fayetteville VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 June 23, 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 accomplishment was the relocation of the inpatient psychiatric unit to a newly renovated space called the Bright Beginnings Recovery Unit. The unit uses a multidisciplinary team approach to provide psychosocial groups focusing on recovery.

Recommendations: We made recommendations in the following six activities:

Quality Management: Require that the Critical Care Committee reviews each code episode. Ensure the Surgical Work Group continues to meet monthly, documents its review of required performance data elements and National Surgical Office reports, and reviews all surgical deaths with identified problems or opportunities for improvement. Require that the Blood Usage Review Committee representative from Surgical Service consistently attends meetings and that the blood/transfusions usage review process includes the results of proficiency testing and the results of inspections by government or private (peer) entities.

Environment of Care: Ensure that Environment of Care Committee minutes reflect discussion of actions taken in response to identified deficiencies and that actions are tracked to closure. Promptly remove expired medications from patient care areas.

Acute Ischemic Stroke Care: Revise the facility's stroke policy to address data gathering for analysis and improvement. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the critical care unit and the acute inpatient unit. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans.

Magnetic Resonance Imaging Safety: Ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and are signed by the patient, family member, or caregiver. Document resolution in patients' electronic health

records of all identified magnetic resonance imaging contraindications prior to the scan. Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Construction Safety: Include in inspection documentation the time of the inspection, the team members present, and the time when corrective actions occurred. Ensure that Construction Safety Committee minutes contain documentation of unsafe conditions identified during inspections and follow-up actions in response to those conditions and that minutes track actions to completion.

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 22–29, for the full text of the Directors comments.) We consider recommendation 9 closed. We will follow up on the planned actions for the open recommendations 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
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety
- 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 2013 and FY 2014 through July 3, 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 Fayetteville VA Medical Center, Fayetteville, North Carolina,* Report No. 12-03071-53, December 10, 2012). We made a repeat recommendation related to EOC Committee minutes.

During this review, we presented crime awareness briefings for 321 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 350 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 Accomplishment

MH Treatment Using Recovery Principles

On January 21, 2014, the facility relocated the inpatient psychiatric unit to a newly renovated space called the Bright Beginnings Recovery Unit. The goal of this unit is to provide a safe place for veterans to transition from crisis to recovery using the following 10 key components of recovery: (1) self-direction, (2) individualized and person-centered, (3) empowerment, (4) holistic, (5) non-linear, (6) strengths-based, (7) peer support, (8) respect, (9) responsibility, and (10) hope. The unit uses a multidisciplinary team approach to provide psychosocial groups focusing on recovery, and there are 10 groups per day. This multidisciplinary team approach has increased veteran participation in these groups by 50 percent.

Prior to relocating to the new unit, the multidisciplinary team identified the need for implementation of other therapeutic intervention techniques, such as de-escalation and communication, as a means to avoid episodes of physical restraints on the unit. Training and education on adverse outcomes with the use of restraints as well as the effects on the veterans' dignity and self-worth was provided. As a result of the additional training and education, there have been zero restraint episodes since October 2013.

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.[a]

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.	
X	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.	Twelve months of Critical Care Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each episode.
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. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group did not meet until January 2014. As a result, there was no evidence that required monthly and quarterly performance data elements, such as local performance data and National Surgical Office reports, were reviewed. Several surgical deaths that occurred from January through June 2013 received final peer review level II or III: • There was no evidence that these deaths were reviewed by the Surgical Work Group.
	Critical incidents reporting processes were appropriate.	
	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.	
	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.	Four quarters of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Surgical Service attended only two of four meetings. • The review process did not include the results of proficiency testing or the results of inspections by government or private (peer) entities.
	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.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the Critical Care Committee reviews each code episode.

2. We recommended that the Surgical Work Group continue to meet monthly and document its review of required performance data elements and National Surgical Office reports.

3. We recommended that processes be strengthened to ensure that all surgical deaths with identified problems or opportunities for improvement are reviewed by the Surgical Work Group.

4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee representative from Surgical Service consistently attends meetings and that the blood/transfusions usage review process includes the results of proficiency testing and the results of inspections by government or private (peer) entities.

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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected MH unit 5C, CLC unit 4A, medical/surgical unit 3C, the intensive care unit, the emergency department, the Indigo Primary Care Clinic, the infusion clinic, SDS, the PACU, and the eye clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 28 employee training records (14 SDS, 9 PACU, and 5 eye clinic). 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
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions were discussed and tracked to closure. This was a repeat finding from the previous CAP review.
	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.	
X	Medication safety and security requirements were met.	• We found expired medications in three of seven patient care areas.
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

5. We recommended that processes be strengthened to ensure that Environment of Care Committee minutes reflect discussion of actions taken in response to identified deficiencies and that actions are tracked to closure.

6. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and that compliance be monitored.

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.[c]

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.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 5 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.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 24 patients who experienced stroke symptoms, and 10 employee training records (5 emergency department and 5 critical care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, one critical care unit, and one acute inpatient unit. 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
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility's policy/plan/guideline did not address data gathering for analysis and improvement.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the applicable 18 EHRs contained documented evidence of completed stroke scales.
NA	Clinicians provided medication tissue plasminogen activator timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the critical care unit or the acute inpatient unit.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Three of the applicable 16 EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• Fifteen of the applicable 16 EHRs did not contain documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff involved in assessing and treating stroke patients.	
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

7. We recommended that the facility's stroke policy be revised to address data gathering for analysis and improvement and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

9. We recommended that stroke guidelines be posted on the critical care unit and the acute inpatient unit.

10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility 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.[f]

We reviewed 13 EHRs of residents (10 residents receiving restorative nursing services and 3 residents not receiving restorative nursing services but candidates for services). We also observed two residents during two meal periods, reviewed five 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.	
X	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.	• In 3 of the 10 applicable EHRs, facility staff did not complete and document restorative nursing services according to clinician orders and/or 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	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 39 employees (30 randomly selected Level 1 ancillary staff and 9 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 33 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. 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 completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Four EHRs (12 percent) did not contain secondary patient safety screenings prior to MRI. • None of the 29 secondary patient safety screening forms were signed by the patient, family member, or caregiver prior to MRI.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Six of the applicable seven EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Nine Level 1 ancillary staff (30 percent) did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

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

Recommendations

13. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are signed by the patient, family member, or caregiver and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

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.[h]

We inspected the Ward C Fan Coil Project, 4th Floor. Additionally, we reviewed relevant documents and 17 training records (7 contractor records and 10 employee 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.	
	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, team members present, and the time when corrective actions occurred.
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
X	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	Construction Safety Committee minutes for past 2 quarters reviewed: • Unsafe conditions were not documented in two of six inspections. • Although unsafe conditions were documented in four of six inspections, there was no evidence of follow-up actions in the minutes.
	Contractors and designated employees received required training.	

NM	Areas Reviewed (continued)	Findings
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

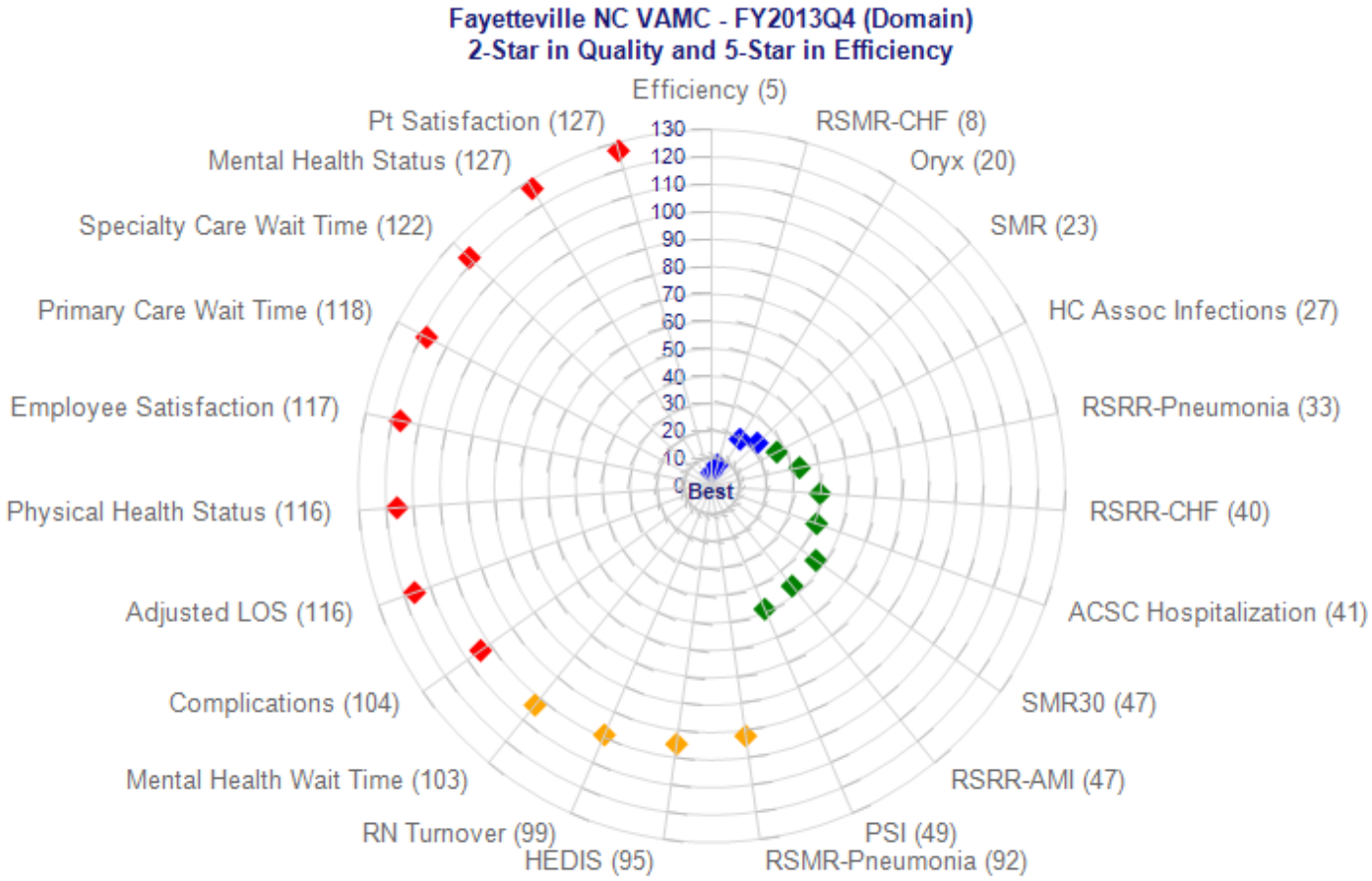
17. We recommended that processes be strengthened to ensure that construction site inspection documentation includes the time of the inspection, the team members present, and the time when corrective actions occurred.

18. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of unsafe conditions identified during inspections and follow-up actions in response to those conditions and that minutes track actions to completion.

Facility Profile (Fayetteville/565) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$288.3
Number of:	
• **Unique Patients**	52,972
• **Outpatient Visits**	373,763
• **Unique Employees**[2]	1,250
Type and Number of Operating Beds:	
• **Hospital**	60
• **CLC**	69
• **MH**	NA
Average Daily Census (as of May 2014):	
• **Hospital**	31
• **CLC**	52
• **MH**	NA
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Jacksonville/565GA New Hanover/565GC Hamlet/565GD Robeson/565GE Goldsboro/565GF
VISN Number	6

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

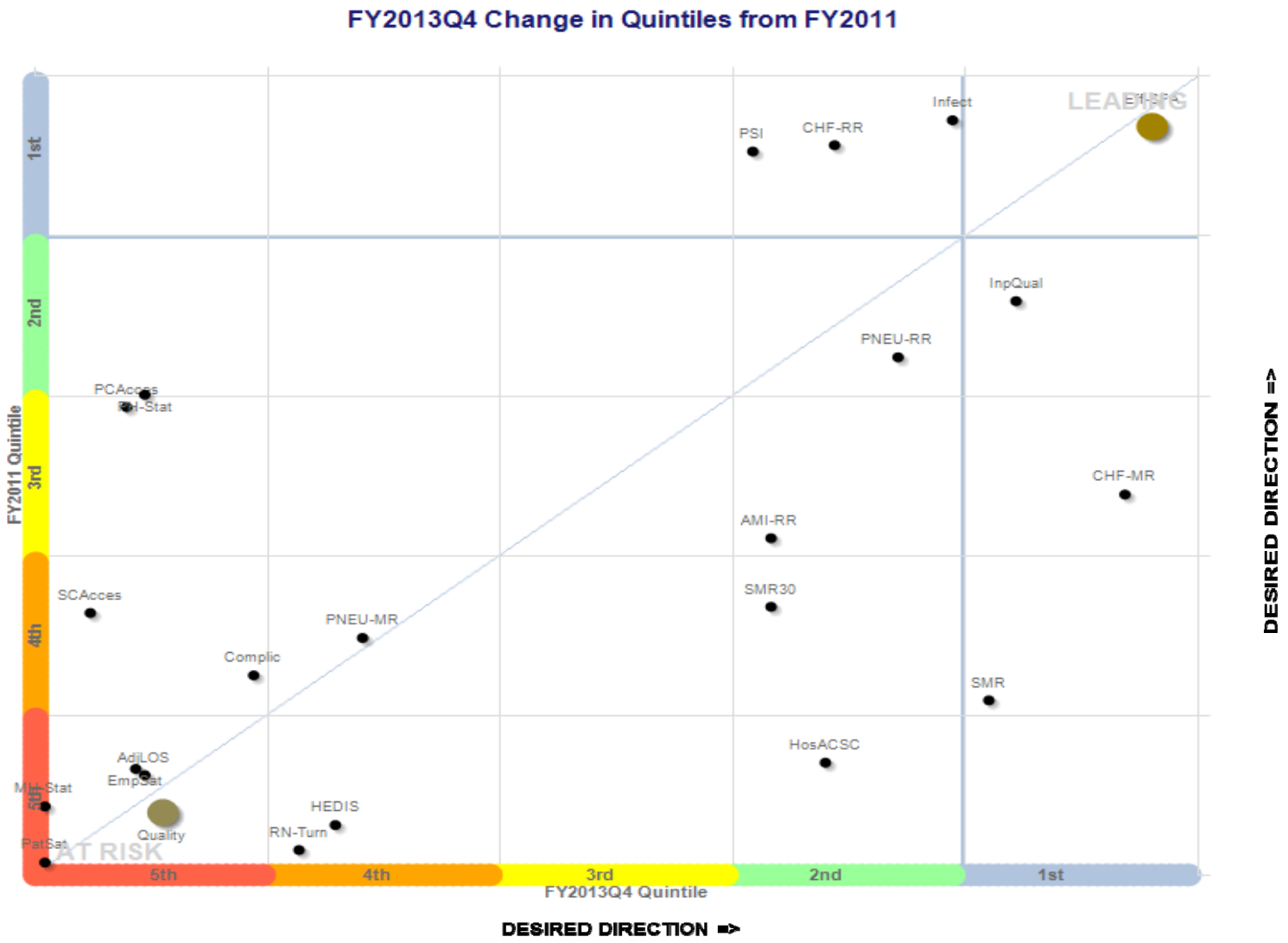
Strategic Analytics for Improvement and Learning (SAIL)[3]



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.

[3] 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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower 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; FY13 and later)	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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	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; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2014

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

Subject: **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

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

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

1. Thank you for the opportunity to provide a status report on the draft findings from the OIG CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC.

2. Attached please find the facility concurrences and responses to the findings from the review.

3. If you have questions or need further information, please contact Lisa Shear, QMO, VISN 6, at (919) 856-5541.

DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2014

From: Director, Fayetteville VA Medical Center (565/00)

Subject: **CAP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

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

Fayetteville VA Medical Center concurs with the findings brought forth in this report. Specific corrective actions have been provided for the recommendations.

Should you have any questions, please contact Damaris Reyes, Chief, Performance Improvement, at 910-822-7091.

(original signed by:)
Elizabeth Goolsby

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 the Critical Care Committee reviews each code episode.

Concur

Target date for completion: 12/31/14

Facility response: Effective July 24, 2014, the Critical Care Committee minutes reflects review and discussion of each resuscitative effort event. Oversight of compliance with these actions will be reported monthly to the Medical Executive Board.

Recommendation 2. We recommended that the Surgical Work Group continue to meet monthly and document its review of required performance data elements and National Surgical Office reports.

Concur

Target date for completion: 12/31/14

The Surgical Workgroup has reviewed the national directive and has amended the agenda to reflect all required elements as standing items for meetings. The minutes will accurately reflect discussion of these requirements. Oversight of compliance with this recommendation will be reported monthly to Medical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that all surgical deaths with identified problems or opportunities for improvement are reviewed by the Surgical Work Group.

Concur

Target date for completion: 12/31/14

Facility response: All surgical deaths will be reviewed at the monthly Morbidity and Mortality meeting. Lessons learned will be discussed at the Surgical Work Group meeting as an opportunity for quality improvement initiative. Oversight of compliance with this recommendation will be reported monthly to Medical Executive Board.

Recommendation 4. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee representative from Surgical Service consistently attends meetings and that the blood/transfusions usage review process includes the results of proficiency testing and the results of inspections by government or private (peer) entities.

Concur

Target date for completion: 12/31/14

Facility response: In order to facilitate attendance of surgical service representatives, effective June 2014 Blood Utilization Committee meeting times was changed from 2:00 P.M. to 3:30 P.M. The importance of meeting attendance has been communicated to all members and their respective Service Chiefs. Meeting agenda was modified to add as standing items the results of proficiency testing and the results of inspections by government or private (peer) entities. Oversight of compliance with this recommendation will be reported monthly to Medical Executive Board.

Recommendation 5. We recommended that processes be strengthened to ensure that Environment of Care Committee minutes reflect discussion of actions taken in response to identified deficiencies and that actions are tracked to closure.

Concur

Target date for completion: 12/31/14

Facility response: Revision of the Fayetteville Environment of Care minutes was completed on July 28, 2014. Minutes now include sufficient detail and capture the discussion by the committee and tracks progress through to completion for open items. The Environment of Care chair is using a couple of standardized tools, one of them "for open action items" to ensure tracking until closed and another to assist with ensuring "quality of minutes." Additionally, the Environment of Care chair has enlisted an independent review of the next 3 months of Environment of Care minutes to be completed by the VISN Quality Management Officer. Corrections and changes will be made as feedback is received.

Recommendation 6. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Staff education concerning processes related to timely removal of all medications will be completed by 8/15/2014. Adherence to this process will be validated during weekly inspections in patient care areas beginning 8/18/14. Oversight

of compliance with this process will be reported monthly to the Pharmacy, Therapeutics and Nutrition Committee.

Recommendation 7. We recommended that the facility's stroke policy be revised to address data gathering for analysis and improvement and that compliance be monitored.

Concur

Target date for completion: 8/31/14

Facility response: The facility's stroke policy has been revised to include the process by which data is gathered and analyzed. It is currently awaiting concurrence.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Appropriate staff have received education related to the National Institutes of Health Stroke Scale template and documentation requirements for all patients with stroke symptoms. Oversight of compliance with this process will be reported monthly to Medical Executive Board.

Recommendation 9. We recommended that stroke guidelines be posted on the critical care unit and the acute inpatient unit.

Concur

Target date for completion: 6/24/14

Facility response: Stroke guidelines and National Institutes of Health Stroke Scale were posted in the Critical Care and Acute Inpatient Unit on 6/24/2014.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: 12/31/14

Facility response: Appropriate staff were provided education on the need to complete a patient screen for difficulty swallowing prior to oral intake. A template to document these results was developed and is currently in use. Oversight of compliance with this process will be reported monthly to the Medical Executive Board.

Recommendation 11. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: An Acute Ischemic Stroke patient education brochure has been created. This information will be provided to patients upon discharge. Compliance with this process will be reported monthly to the Medical Executive Board.

Recommendation 12. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: All licensed staff was educated on the requirements for completion and documentation of restorative nursing services according to clinician orders and/or residents' care plans. All restorative care plans will be reviewed monthly and oversight reported to the Nurse Executive Council.

Recommendation 13. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: The magnetic resonance imaging technologists were retrained July 1, 2014 on the importance of completing the second level safety screening for all magnetic resonance imaging patients. The Chief Technologist in Imaging Service is performing 100% verification that all questionnaires are being fully completed and are accurate. The results of this verification process will be reported monthly at the Medical Executive Board meeting.

Recommendation 14. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are signed by the patient, family member, or caregiver and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Patients are being provided a screening form in hard copy. The patient completes the form and gives to technologist. The technologist then reviews the form with patient and transcribes the information into the electronic template in CPRS. The form is then printed and given to the patient for review and signature. Chief Technologist is performing 100% verification that all screenings are complete and accurate. The results of this verification process will be reported monthly at the Medical Executive Board meeting.

Recommendation 15. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Technologists have been instructed to explain how/why it is safe for patient to enter the magnet after a positive response to a safety item has been given. The technologists are to number and list all positive answers in the comments portion of the electronic questionnaire template. Chief Technologist is performing 100% verification that explanations are listed for all positive contraindications. The results of this verification process will be reported monthly at the Medical Executive Board meeting.

Recommendation 16. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: 12/31/14

Facility response: Imaging Service Manager will complete a random sampling of ancillary staff to ensure that all required individuals have completed Level I MRI Safety Training course on TMS. The results of this verification process will be reported monthly at the Medical Executive Board meeting.

Recommendation 17. We recommended that processes be strengthened to ensure that construction site inspection documentation includes the time of the inspection, the team members present, and the time when corrective actions occurred.

Concur

Target date for completion: 12/31/14

Facility response: Revision of the Fayetteville site inspection document was completed on 9 June 2014. This document has a place to annotate the names of all members that

are present during the construction site safety inspections, time of the inspection and date the corrective action was completed.

Recommendation 18. We recommended that processes be strengthened to ensure that Construction Safety Committee minutes contain documentation of unsafe conditions identified during inspections and follow-up actions in response to those conditions and that minutes track actions to completion.

Concur

Target date for completion: 12/31/14

Facility response: Revision of the Fayetteville Construction Safety minutes was completed on 9 June 2014. The minutes now include a list of unsafe conditions (deficiencies) identified by the inspection team. Deficiencies are being tracked until closed including completion date, responsible person, and corrective actions.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Toni Woodard, BS, Team Leader Victoria Coates, LICSW/MBA Sheyla Desir, RN,MSN Joanne Wasko, LCSW Robert Lachapelle, Resident Agent, Fayetteville, NC, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Lesa Gann, RN, LCSW Jeff Joppie, BS Nathan McClafferty, MS Anita Pendleton, AAS Patrick Smith, M. Stat Julie Watrous, RN, MS Jarvis Yu, MS

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This report is available at www.va.gov/oig.

Endnotes

[a] 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.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] 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, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] 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, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] 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.

[g] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[h] 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 (OSHA) regulations.