Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04229-130

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

February 25, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
ED	Emergency Department
EHR	electronic health record
EOC	environment of care
facility	Beckley VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
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 December 8, 2014.

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

- Coordination of Care
- Surgical Complexity

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure the Chief of Staff consistently attends meetings of the newly established Surgical Work Group. Require that service lines report electronic health record quality data to the Electronic Health Record Committee and that the committee analyzes the data at least quarterly.

Environment of Care: Ensure patient care areas and Emergency Department restrooms are clean and in good repair. Require that nurse call system alarms in the Emergency Department are audible and visual.

Medication Management: Ensure designated employees receive initial automated dispensing machine training and competency assessment.

Magnetic Resonance Imaging Safety: Conduct initial patient safety screenings. Document referrals to a radiologist for patients identified as having applicable conditions during secondary screenings.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Provide printed stroke education to patients upon discharge. Collect and report all required data elements to the Veterans Health Administration.

Emergency Airway Management: Assess clinicians for emergency airway management competency prior to granting of privileges. Require that initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients. Ensure completion of clinician reassessment for continued emergency airway management competency at the time of renewal of privileges. Require that a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care.

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–34, 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
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

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, FY 2014, and FY 2015 through December 8, 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 Beckley VA Medical Center, Beckley, West Virginia,* Report No. 12-00883-189, May 30, 2012).

During this review, we presented crime awareness briefings for 37 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 167 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.

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, nine credentialing and privileging folders, 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.		
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	Twelve months of Operative, Anesthesia, and Other Invasive Procedures Committee meeting minutes reviewed: • The Chief of Staff was not a member. In October 2014, the facility created a new Surgical Work Group that includes the Chief of Staff as a member. However, at the time of our onsite visit, there had not yet been any Surgical Work Group meetings.	**1.** We recommended that the Chief of Staff consistently attend meetings of the newly established Surgical Work Group.
NA	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • The committee did not analyze EHR quality data quarterly because the service lines did not consistently report data to the committee.	**2.** We recommended that the facility ensure service lines report electronic health record quality data to the Electronic Health Record Committee and that the committee analyze the data at least quarterly.
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the medical/surgical unit; the critical care unit; the ED; two primary care clinics; the MH, spinal cord injury, and women's health outpatient clinics; and two CLC units. We also performed a perimeter inspection of the ED construction site. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 30 employee training records (10 critical care and 20 CLC) and 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 for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Six of seven patient care areas had chipped walls, doors, and/or doorframes. • Two of seven patient care areas had dirty stainless steel expansion joints in the floor. • Staff and public restrooms in the ED had cracked floor tiles and were dirty. • Nurse call system alarms in the ED were not audible and visual.	**3.** We recommended that facility managers ensure patient care areas are clean and in good repair and monitor compliance. **4.** We recommended that facility managers ensure restrooms in the Emergency Department are clean and in good repair and monitor compliance. **5.** We recommended that facility managers ensure the nurse call system alarms in the Emergency Department are audible and visual and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
X	The facility met environmental safety requirements in critical care.	• The intensive care unit main hallway had cracked floor tiles.	See recommendation 3.
	The facility met infection prevention requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• The CLC units had chipped walls, doors, and/or doorframes. • Stainless steel expansion joints in CLC unit floors were dirty. • CLC patient showers were dirty and had cracked tiles.	See recommendation 3.

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the ED, post-anesthesia care unit, medical/surgical unit, and intensive care unit and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Four nursing employees did not have documentation of initial training and competency assessment for automated dispensing machines.	**6.** We recommended that facility managers ensure designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
NA	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
NA	The facility met multi-dose insulin pen requirements.		

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

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 37 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. 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	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

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.[e]

We reviewed relevant documents and the training records of 33 employees (30 randomly selected Level 1 ancillary staff and 3 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 34 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one 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	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Twenty-four EHRs (71 percent) did not contain initial patient safety screenings.	**7.** We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
X	The facility complied with any additional elements required by VHA or local policy.	Facility secondary screening forms require Level 2 personnel to refer patients to a radiologist for review if they identify certain conditions. • There was no documentation that Level 2 personnel referred any of the 25 applicable patients to a radiologist for review.	**8.** We recommended that Level 2 personnel document referral to a radiologist of patients identified as having applicable conditions during secondary screening and that facility managers monitor compliance.

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.[f]

We reviewed relevant documents and the EHRs of 14 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the ED, one critical care unit, one acute inpatient unit, and two CLC units. 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	Recommendations
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Clinicians did not document evidence of completion of stroke scales for any of the nine applicable patients.	**9.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
X	Clinicians provided printed stroke education to patients upon discharge.	• For four of the six applicable patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**10.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not collect or report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator • The facility did not report the following data to VHA: o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**11.** We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to its assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 18 employees, and we conversed with key managers and employees. 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	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 10 clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and 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	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		

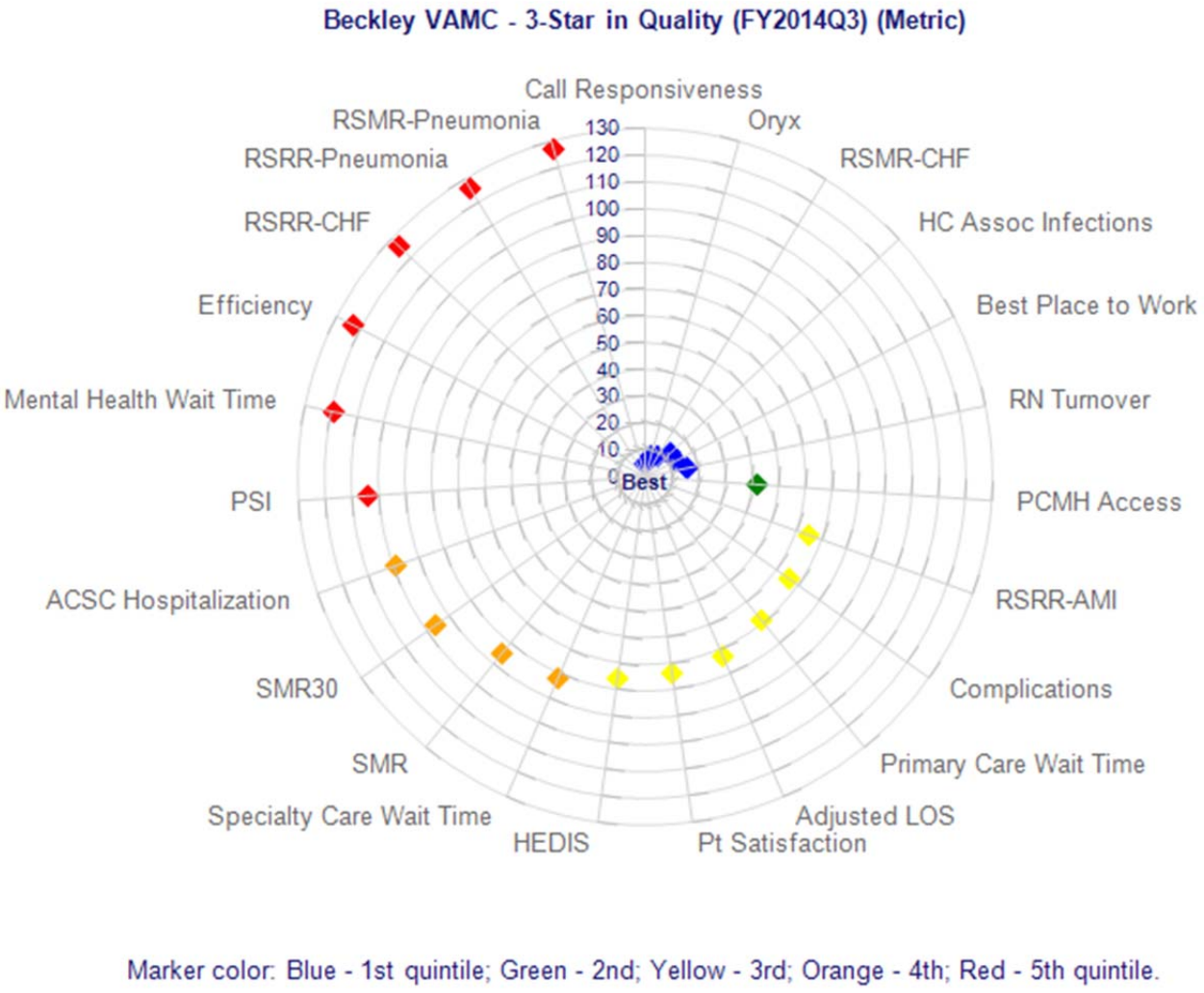
NM	Areas Reviewed (continued)	Findings	Recommendations
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• Five of seven applicable clinicians did not have EAM competency completed prior to granting of EAM privileges. • Neither of the two clinicians with initial EAM competency assessment had evidence of successful demonstration of all required procedural skills on patients.	**12.** We recommended that the facility ensure assessment of clinicians for emergency airway management competency prior to granting of privileges and that facility managers monitor compliance. **13.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the three applicable clinicians had reassessments for continued EAM competency completed at the time of renewal of privileges.	**14.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	• Twenty-five of 30 sampled days (83 percent) did not have EAM coverage during all hours the facility provided patient care.	**15.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Beckley/517) FY 2015 through December 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$100.1
Number of:	
• **Unique Patients**	9,795
• **Outpatient Visits**	35,058
• **Unique Employees**[2]	660
Type and Number of Operating Beds (as of November):	
• **Hospital**	40
• **CLC**	50
• **MH**	NA
Average Daily Census (as of November):	
• **Hospital**	16
• **CLC**	25
• **MH**	NA
Number of Community Based Outpatient Clinics	1
Location(s)/Station Number(s)	Maxwelton/517GB
VISN Number	6

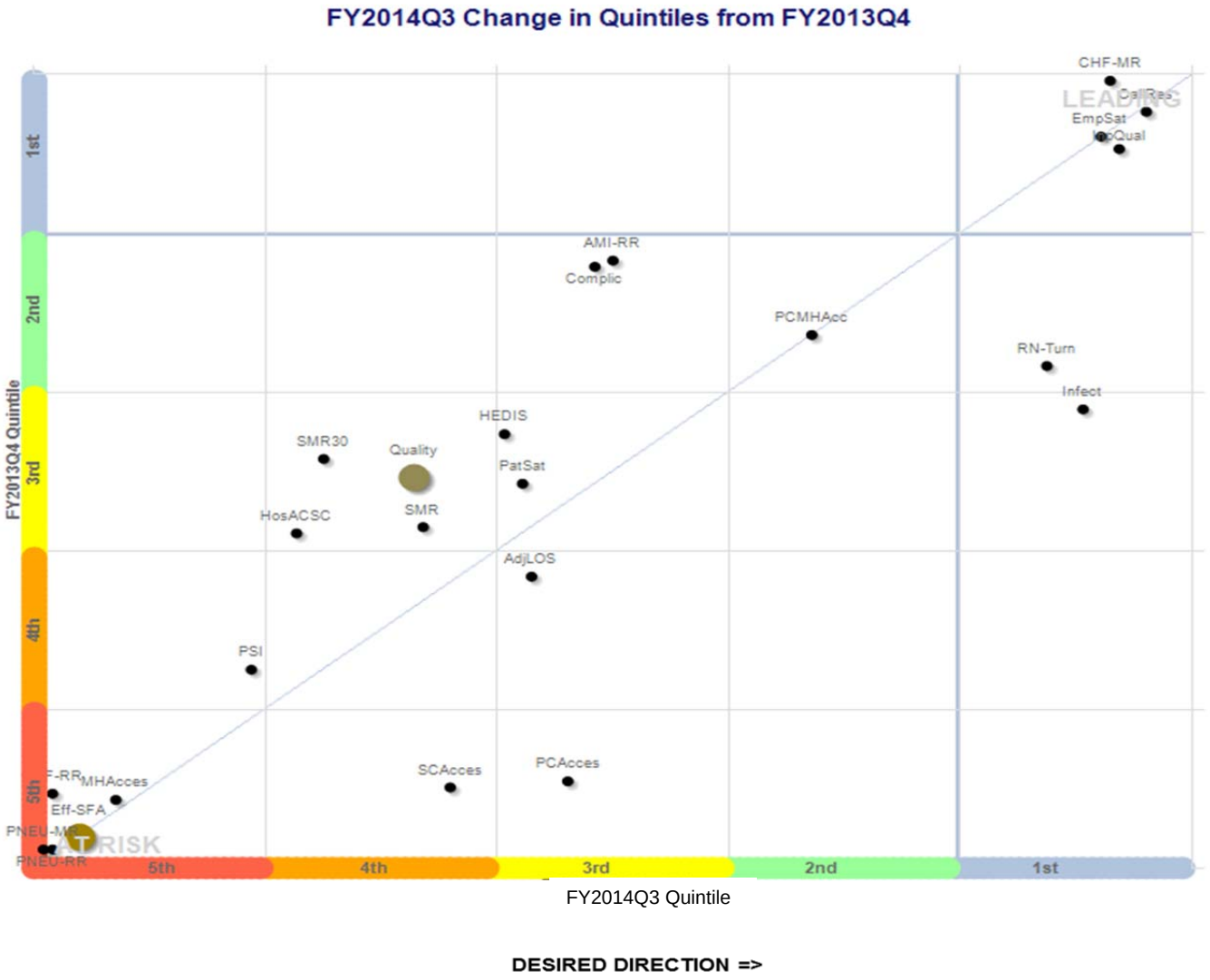
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[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

Acting VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 30, 2015

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

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

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive review conducted December 9–11, 2014.

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

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

Lisa Shear, QMO, VISN 6,
for and in the absence of,
DANIEL F. HOFFMANN, FACHE
VISN 6 Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 26, 2015

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

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

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

1. I would like to express my appreciation to the Office of Inspector General Survey Team for their professional and comprehensive review conducted December 9–11, 2014.

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

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

Karin L. McGraw, MSN, FACHE
Director, Beckley VA Medical Center

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 Chief of Staff consistently attend meetings of the newly established Surgical Work Group.

Concur

Target date for completion: 5/31/2015

Facility response: As of January 2015, the Chief of Staff is a standing member of the Medical Center Facility Surgical Workgroup Committee. The first meeting was held January 28, 2015, with the Chief of Staff in attendance. Attendance is monitored and tracked through the Surgical Workgroup Committee.

Recommendation 2. We recommended that the facility ensure service lines report electronic health record quality data to the Electronic Health Record Committee and that the committee analyze the data at least quarterly.

Concur

Target date for completion: 7/31/2015

Facility response: To ensure timely reporting of Point of Care Reviews by the Service Lines, the reporting calendar has been revised to allow time for service data aggregation and analysis. Services scheduled to report Point of Care Reviews have been provided a copy of the reporting calendar. If the committee member is unable to attend, the report may be submitted electronically to the chairperson or a designee may present in their absence. To ensure timely reporting of Point of Care Reviews by the Service Lines a tracking tool has been implemented effective 1-13-15. Timely reporting of Point of Care reviews will be monitored and reported through the Medical Records Committee. MCM 517-2015-136C-02 Medical Record Committee has been updated to reflect the changes and is currently in the review process with implementation expected for 3-1-15.

Recommendation 3. We recommended that facility managers ensure patient care areas are clean and in good repair and monitor compliance.

Concur

Target date for completion: 10/1/15 date for the completion of recommended six findings as target dates are staggered through FY 2015.

Facility response: Beckley VAMC Facility Management Service Line (FMSL) will conduct a walkthrough inspection of all patient care areas (inpatient and outpatient) to identify locations that require repair work on the floors, walls and ceilings. These locations will be documented and a schedule of work will be completed to repair these areas. The medical center's Environment of Care (EOC) team will focus the rounds to specifically look for these conditions. All findings will be tracked through the Safety and Environment of Care Committee until the corrective actions are completed.

Recommendation 4. We recommended that facility managers ensure restrooms in the Emergency Department are clean and in good repair and monitor compliance.

Concur

Target date for completion: 5/31/2015

Facility response: All bathrooms/showers are cleaned daily and throughout the day as needed. The cracked/stained floor tiles will be replaced by BES Contracting with a completion date set for April 1, 2015. Housekeeping inspects the ED and public restrooms in the ED waiting area for cleanliness and maintenance issues. The facility EOC Rounds team will monitor the ED for damaged floors, walls and ceilings and will monitor cleanliness the area and restrooms. Findings of the EOC rounds will be tracked by the Safety and Environment of Care Committee until completion.

Recommendation 5. We recommended that facility managers ensure the nurse call system alarms in the Emergency Department are audible and visual and monitor compliance.

Concur

Target date for completion: 7/1/2015

Facility response: The ED Nurse Call system has been reactivated and is operational in four of the six examination rooms. Biomedical Engineering and Facilities Management Engineering staff is working to complete the installation of the pull cord and push button system for the nurse call system in the two remaining rooms. In the interim, hand held bells are provided to the patients who may be placed in these rooms. The medical center's nurse call system has been placed on a Preventative Maintenance schedule to verify that it is functioning correctly. The Nurse Call system deficiencies will be reported to the Safety and Environment of Care (EOC) committee quarterly effective 2nd quarter 2015.

Recommendation 6. We recommended that facility managers ensure designated employees receive initial automated dispensing machine training and competency assessment and monitor compliance.

Concur

Target date for completion: 5/31/2015

Facility response: As of January 23, 2015, 100 percent (96/96) of the nursing staff have verified competency assessment for automated dispensing machines. The Initial automated dispensing training and competency assessment is completed in unit specific nursing orientation; proof of competency assessment will be maintained in the employee competency folder. To ensure oversight, monthly compliance of completed initial Omnicell training and competencies will be reported to the Clinical Bar Code Multidisciplinary Committee effective February 2015.

Recommendation 7. We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.

Concur

Target date for completion: 8/31/2015

Facility response: Beginning March 2015, the Patient Care Coordinator MRI Technician will review 30 charts per month for the completion of the initial MRI screening form. The monthly results will be reported to the MRI Safety Committee as of April 2015. Corrective action plans will be formulated for any identified deficiencies and tracked through the MRI Safety Committee until completed. All results will be reported quarterly to leadership through the Clinical Executive Board.

Recommendation 8. We recommended that Level 2 personnel document referral to a radiologist of patients identified as having applicable conditions during secondary screening and that facility managers monitor compliance.

Concur

Target date for completion: 8/31/2015

Facility response: Beginning March 2015, the Patient Care Coordinator MRI Technician will review 30 charts per month for accurate completion of the secondary screening form and evidence of referral to the radiologist when appropriate as evidenced by a progress note in CPRS. The monthly results will be reported to the MRI Safety Committee monthly as of April 2015. Corrective action plans will be formulated for any identified deficiencies and tracked through the MRI Safety Committee until completed. All results will be reported quarterly to leadership through the Clinical Executive Board.

Recommendation 9. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: 7/31/2015

Facility response: Effective January 2015, 100 percent of all patients presenting to the Emergency Department with signs or symptoms of a stroke are being monitored for evidence of documentation of the National Health Institute Stroke Scale. A concurrent monitor checklist identifying documentation requirements inclusive of the NIH stroke scale is being used in collaboration with a second nurse verifier to ensure all documentation requirements are completed. Monthly data will be collected and reported to the ICU Committee until greater than 90 percent compliance is sustained with quarterly reporting to the Clinical Executive Board.

Recommendation 10. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: 7/31/2015

Facility response: Effective January 2015, 100 percent of all patients presenting to the Emergency Department with signs or symptoms of a stroke is being monitored for evidence of documentation of the printed stroke patient education upon discharge. A concurrent monitor checklist identifying documentation requirements inclusive of the printed patient/family stroke education is being used in collaboration with a second nurse verifier to ensure all documentation requirements are completed. Monthly data is being collected and reported to the ICU Committee until greater than 90 percent compliance is sustained with quarterly reporting to the Clinical Executive Board.

Recommendation 11. We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: 7/31/2015

Facility response: Collection of required Acute Ischemic Stroke Quality Indicator Data for 1st Quarter FY15 was completed by ED Clinical Care Coordinator in January 2015. 1st Quarter Stroke Data was reported to the facility's ICU Committee on January 16, 2015, and will be reported monthly beginning February 2015 with target compliance of 90 percent or greater. Concurrent monitoring of each patient who

presents to the ED with stroke symptoms will be completed by ED staff nurse effective February 2015. Quarterly reporting of data trends will be presented to CEB in the second quarter of 2015.

Recommendation 12. We recommended that the facility ensure assessment of clinicians for emergency airway management competency prior to granting of privileges and that facility managers monitor compliance.

Concur

Target date for completion: 5/31/2015

Facility response: As of December 2014, Hospitalists, Gap Providers and physicians in the Emergency Department (ED) have demonstrated competence in accordance with MCM 517-2014-11-32, "Out of Operating Room (OR) Airway Management" and are currently privileged in Emergency Airway Management. Processes are in place to ensure emergency airway management competence has been completed prior to the Professional Standards Board granting privileges for Out of OR Airway Management. The VetPro report titled 'Providers within 6 months of Expiration' is utilized to ensure tracking and compliance. The Credentialing coordinator notifies by memo, the physician, the Service Line Chief, and PSB of the pending expiration dates.

Recommendation 13. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.

Concur

Target date for completion: 5/31/2015

Facility response: New physicians hired for the ED, Hospitalist or Gap physician will not be scheduled as sole provider until requirements are completed as listed: Completion of TMS course #16087 (Out of OR Airway management), simulation lab and successful demonstration of airway management and intubation skills to the Chief of Anesthesia). Privileges will be granted upon completion of competency. Status of initial physician privileges is reported to the Clinical Executive Board following Professional Standard Board recommendation. This will be monitored at time of hire and thereafter, using the VetPro report titled 'Providers within 6 months of Expiration' to ensure tracking and compliance.

Recommendation 14. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges and that facility managers monitor compliance.

Concur

Target date for completion: 5/31/2015

Facility response: As of December 2014, in accordance with in accordance with MCM 517-2014-11-32 Out of Operating Room (OR) Airway Management physicians in the ED, Hospitalists and Gap Providers have demonstrated competence and are privileged in Out of OR Airway Management. Target completion to synchronize the separate privileges with the Emergency Airway Management privileges is by May 31, 2015, with monthly Professional Standard Board Reports to Clinical Executive Board.

Recommendation 15. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: As of 12/04/2014, as defined by MCM 517-2014-11-32 Out of Operating Room (OR) Airway Management, the physicians in the ED, Hospitalists, and Gap Primary Care Physician have demonstrated competence and are privileged in Out of OR Airway Management, thus ensuring 24 hours of coverage at the medical center during all hours the medical center provides patient care. Emergency Airway Management Coverage will be monitored on a monthly basis and a status report will be reported to CEB quarterly. The Professional Standard Board Committee and the physician will receive a 6 month notification of the Out of OR Airway Management expiration date.

Office of Inspector General
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U.S. House of Representatives: Evan Jenkins

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

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, 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 Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] 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.

[f] 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.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.