Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00628-49

Combined Assessment Program Review of the Salem VA Medical Center Salem, Virginia

December 3, 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

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
ED	Emergency Department
EHR	electronic health record
EOC	environment of care
facility	Salem VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
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 September 21, 2015.

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

- Coordination of Care
- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were providing endovascular aneurysm repair and establishing the Emergency Department Nurse Navigator Program.

Recommendations: We made recommendations in the following six activities:

Quality Management: Review privilege forms annually, and document the review. Ensure licensed independent practitioners' folders do not contain non-allowed information. Require the Critical Care Committee to continue the recently implemented code review process that includes screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Environment of Care: Repair or remove damaged wheelchairs from service, and include wheelchairs in the facility's preventative maintenance program. Ensure that employees follow facility policy for disinfection of non-critical equipment between patients and that exam rooms contain adequate disinfection supplies.

Medication Management: Store medications awaiting destruction separately from medications available for administration, and ensure patient-specific insulin vials distributed to units are consistently labeled with correct expiration dates.

Advance Directives: Correctly post patients' advance directives status. Hold advance directive discussions requested by inpatients, and document the discussions.

Surgical Complexity: Ensure surgical intensive care unit nurses have 12-lead electrocardiogram and post-anesthesia care competency assessment and validation included in their competency checklists.

Emergency Airway Management: Include all required elements in initial clinician emergency airway management competency assessment. Ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.

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 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
- CT Radiation Monitoring
- ADs
- 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 2014 and FY 2015 through September 21, 2015, and inspectors conducted the review 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 Salem VA Medical Center, Salem, Virginia*, Report No. 13-00889-206, May 30, 2013).

During this review, we presented crime awareness briefings for 122 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. We distributed an electronic survey to all facility employees and received 360 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Endovascular Aneurysm Repair

In May 2015, the Chiefs of Imaging and General Surgery Services and a team of eight other providers from interventional radiology, vascular surgery, anesthesiology, and nursing completed a 3-year project to provide endovascular aneurysm repair to treat patients with abdominal aortic aneurysms.[1] This procedure was first pioneered in the early 1990s as a less invasive procedure compared with open repair and is associated with lower surgical morbidity and mortality rates, a faster recuperation period, and reduced length of post-operative hospital stay. During FY 2015, four patients were treated successfully using this procedure, and four additional procedures are scheduled for the 1st quarter of FY 2016.

ED Nurse Navigator Program

In March 2015, ED nursing management, in collaboration with information technology professionals, embedded a mandated field in the Computerized Patient Record System ED discharge note identifying patients who would potentially require follow-up. Specifically, the revised discharge note "flags" the EHR if urgent follow-up or a care

[1] The aorta is a major blood vessel located in the chest and abdomen that supplies oxygenated blood to the upper body. If an area of the abdominal aorta expands, bulges, or enlarges, the affected area is known as an abdominal aortic aneurysm.

coordination action, such as the need to repeat or further review laboratory tests or request specialty consults, is needed. An ED Nurse Navigator reviews the "flagged" discharges within 7 days of patient discharge and ensures appropriate continuity of care. Data is collected, analyzed, and reported monthly to the Utilization and Management Committee.

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, 10 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
X	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.	• Facility managers did not review privilege forms annually. • All 10 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that facility managers review privilege forms annually and document the review. **2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	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.		
X	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.	Twelve months of Critical Care Committee meeting minutes reviewed: • Prior to July 2015, code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code. The committee recently implemented a process change that includes this screening.	**3.** We recommended the Critical Care Committee continue the recently implemented code review process that includes screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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.		
	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.		
	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 emergency management.[b]

We inspected the medical/surgical, the medical, the surgical intensive care, the medical intensive care, the acute behavioral health, and two CLC inpatient units. We also inspected the ED and the primary care, physical medicine/rehabilitation, dialysis, women's health, and specialty clinics and performed a perimeter inspection of the CLC dining room addition construction site. Additionally, we reviewed relevant documents, including 10 employee training and competency records, 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.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Three of seven inpatient units had damaged wheelchairs. • Twenty wheelchairs stored at the facility main entrance for use by patients visiting outpatient clinics were damaged.	**4.** We recommended that facility managers ensure that damaged wheelchairs are repaired or removed from service and that wheelchairs are included in the facility's preventative maintenance program.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Facility policy requires that all employees ensure equipment is appropriately cleaned and disinfected between patients. • Employees in two of six clinics failed to disinfect non-critical equipment between patients. • Multiple exam rooms in two of six clinics lacked supplies for disinfection of non-critical equipment between patients.	**5.** We recommended that facility managers ensure that employees follow facility policy for disinfection of non-critical equipment between patients and that exam rooms contain adequate supplies for disinfection.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
	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 medical/surgical unit, the medical intensive care unit, the ED, and one CLC inpatient 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 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
	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.		
NA	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 monthly, fully implemented corrective actions, and monitored the changes.		
	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.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
X	The facility removed medications awaiting destruction or stored them separately from medications available for administration.	• Two of the four areas inspected did not have medications awaiting destruction stored separately from those available for administration.	**6.** We recommended that facility managers ensure medications awaiting destruction are stored separately from medications available for administration and monitor compliance.
	The facility met multi-dose insulin pen requirements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	Facility standard operating procedure on patient-specific insulin vials requires the pharmacy to label each vial with the correct expiration date: • In two of four areas inspected, we found patient-specific insulin vials labeled with incorrect expiration dates.	**7.** We recommended that facility managers ensure patient-specific insulin vials distributed to units are consistently labeled with correct expiration dates and monitor compliance.

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 28 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.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 14 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 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
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 2014. 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 an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For 14 of the 48 applicable EHRs (29 percent), employees did not correctly post patients' AD status.	**8.** We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Five of the seven applicable EHRs did not contain documentation that employees held the discussions requested.	**9.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.
	The facility met 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 the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 10 nurses, and we conversed with key managers and 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	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Eight of 10 nurses on the surgical intensive care unit did not have 12-lead electrocardiogram or post-anesthesia care competency assessment and validation included in their competency checklists.	**10.** We recommended that facility managers ensure that surgical intensive care unit nurses have 12-lead electrocardiogram and post-anesthesia care competency assessment and validation included in their competency checklists.
NA	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 12 clinicians applicable for the review period January 1–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		

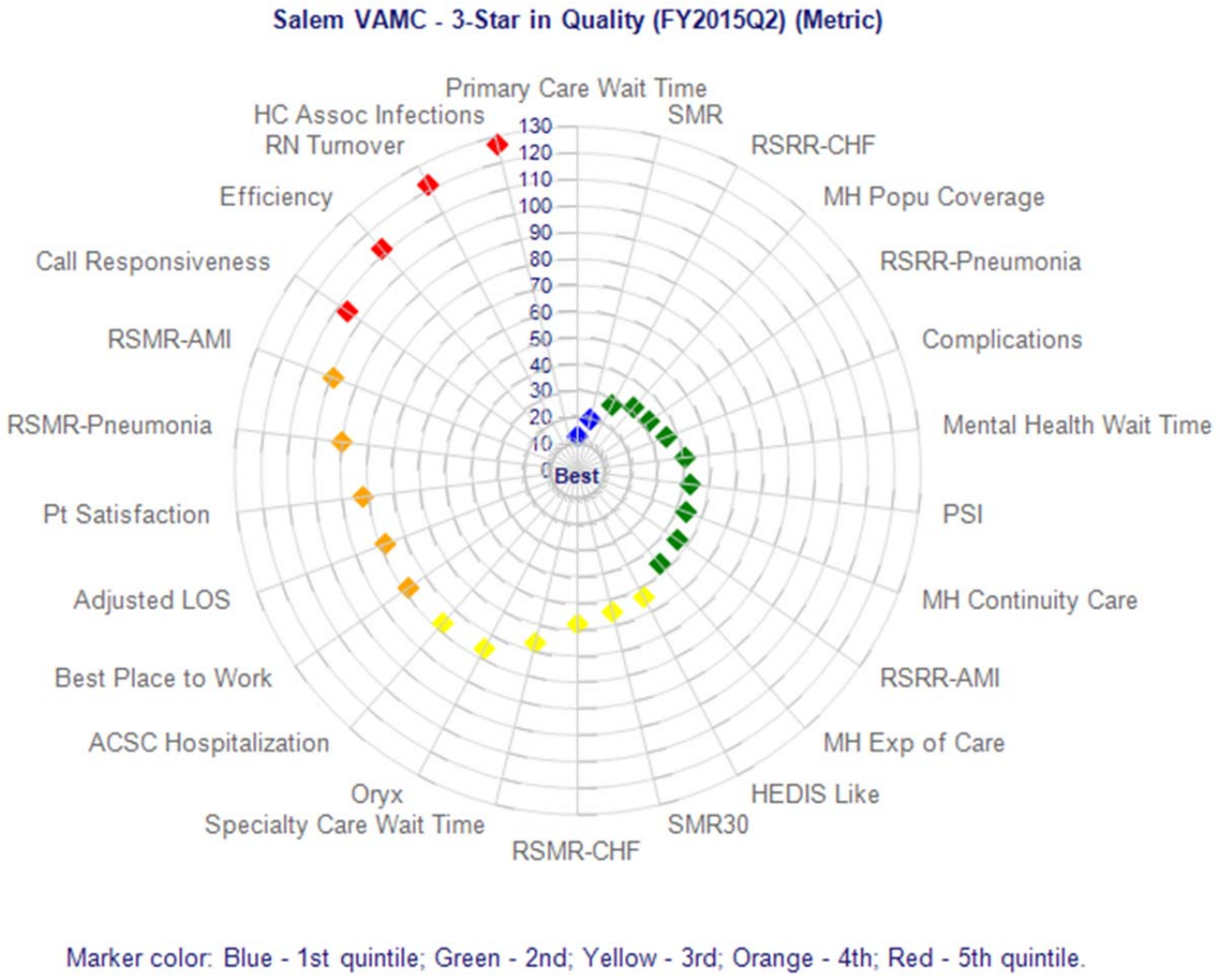
NM	Areas Reviewed (continued)	Findings	Recommendations
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• One of two clinicians with initial EAM competency assessment did not have documentation of all required subject matter content elements or evidence of a completed written test. • Neither of the two clinicians with initial EAM competency assessment had evidence of successful demonstration of all required procedural skills on airway simulators or mannequins or evidence of successful demonstration of all required procedural skills on patients.	**11.** We recommended that the facility ensure that initial clinician emergency airway management competency assessment includes all required subject matter content elements and evidence of a completed written test and that facility managers monitor compliance. **12.** We recommended that the facility ensure that initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and 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 two 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 clinicians with reassessments for continued EAM competency had: o Clinician-specific EAM data reviewed. o Evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.	**13.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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 (Salem/658) FY 2015 through September 2015[2]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions as of August 2015	$312.5
Number of:	
• **Unique Patients**	38,560
• **Outpatient Visits**	442,463
• **Unique Employees**[3]	1,546
Type and Number of Operating Beds:	
• **Hospital**	182
• **CLC**	90
• **MH**	26
Average Daily Census:	
• **Hospital**	74
• **CLC**	48
• **MH**	19
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Tazewell/658GA Danville/658GB Lynchburg/658GC Staunton/658GD Wytheville/658GE
VISN Number	6

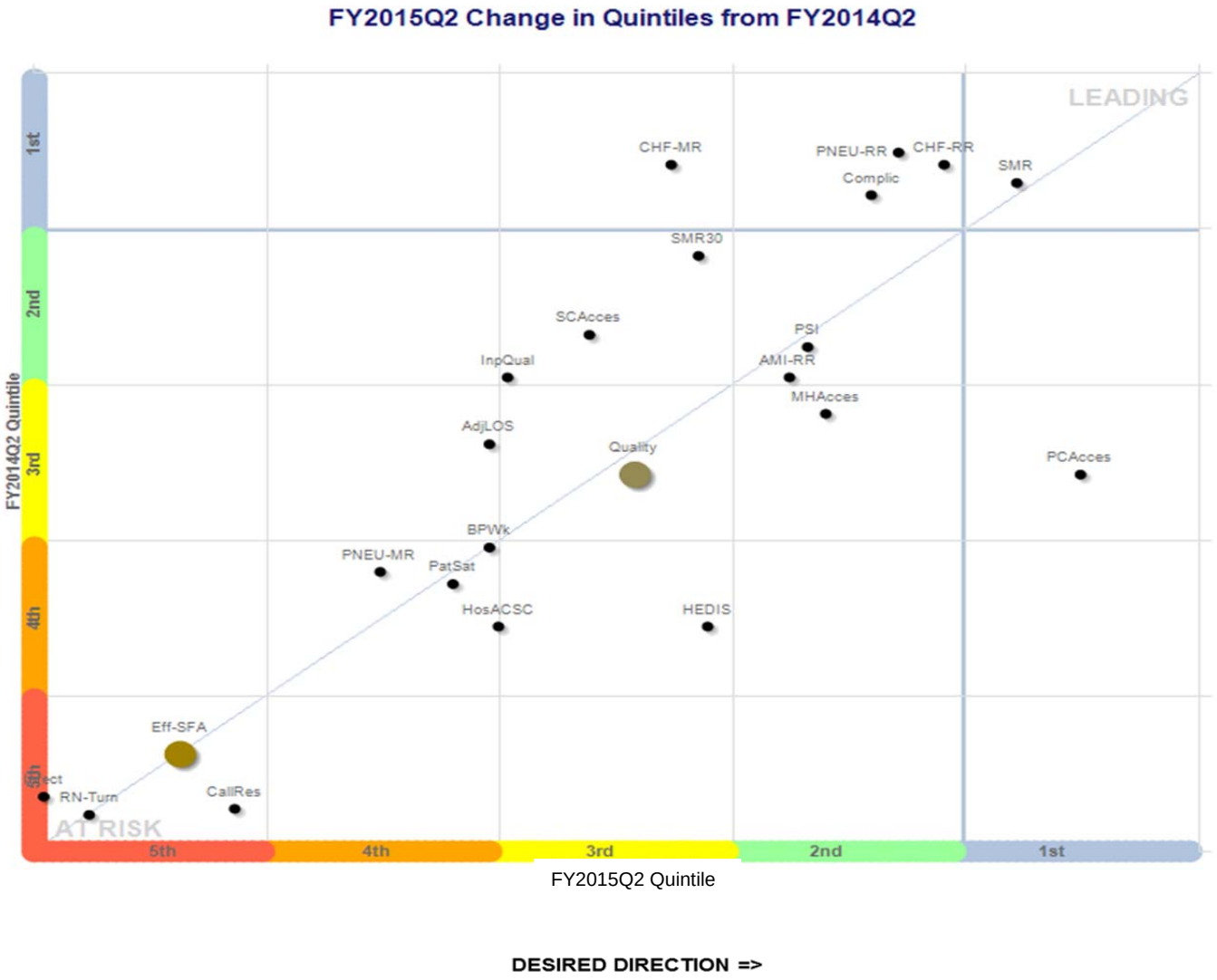
[2] All data is for FY 2015 through September 2015 except where noted.
[3] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[4]



[4] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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: November 9, 2015

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

Subject: **CAP Review of the Salem VA Medical Center Salem, VA**

To: Director, Bedford Office of Healthcare Inspections (54BN)

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

1. I have reviewed and concur with the action plan regarding the Combined Assessment Program (CAP) review of the Salem VA Medical Center, Salem, VA.

2. The facility will ensure that the corrective action plan is implemented.

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

DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 5, 2015

From: Director, Salem VA Medical Center (658/00)

Subject: **CAP Review of the Salem VA Medical Center, Salem, VA**

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

1. I appreciate the opportunity to review the draft report for the OIG CAP Review conducted at the Salem VA Medical Center from September 21–24, 2015 and concur with the recommendations.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing actions to resolve these issues.

3. If you have any questions regarding the response to the recommendations, feel free to call me at (540) 982-2463.

MIGUEL H. LAPUZ, MD, MBA

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 facility managers review privilege forms annually and document the review.

Concur

Target date for completion: April 30, 2016

Facility response: The Credentialing and Privileging Office completed the annual review of all privileging forms and initiated a process to ensure annual review (every twelve months) of all privileging forms going forward. Reviews will be documented by the Credentialing Office and reported to the Medical Executive Board (MEB) monthly until the process is sustained until closure.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: February 29, 2016

Facility response: The Credentialing and Privileging Office reviewed all practitioner credentialing folders and removed all non-allowed information. The process will be maintained by the Credentialing and Privileging Coordinator. Reviews will be documented by the Credentialing Office and reported to the Medical Executive Board (MEB) monthly until the process is sustained until closure.

Recommendation 3. We recommended the Critical Care Committee continue the recently implemented process that includes screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: February 29, 2016

Facility response: The Critical Care Committee now screens each code for any clinical issues prior to the code that may have contributed to the occurrence of the code. Evidence of compliance is documented in the Critical Care Committee minutes. Minutes will be evaluated monthly by Quality Management to ensure appropriate documentation of code reviews and report to MEB until closure.

Recommendation 4. We recommended that facility managers ensure that damaged wheelchairs are repaired or removed from service and that wheelchairs are included in the facility's preventative maintenance program.

Concur

Target date for completion: April 30, 2016

Facility response: All damaged wheelchairs were taken out of service as of September 24, 2015. Wheelchairs are routinely inspected for damage by Voluntary Service staff and any damaged wheelchairs are removed from service until they are repaired. New/replacement wheelchairs were ordered in FY15 and are in the process of being assembled and placed into utilization. A standard operating procedure (SOP) for wheelchair maintenance is under development by Facility Management Service for inclusion into the preventive maintenance program. Once the SOP is developed, involved staff will be trained with evidence of a training record. Volunteer Service will monitor wheelchairs for the absence of damage and ensure compliance with the preventive maintenance process with monthly reporting to the Environment of Care Committee until closure.

Recommendation 5. We recommended that facility managers ensure that employees follow facility policy for disinfection of non-critical equipment between patients and that exam rooms contain adequate supplies for disinfection.

Concur

Target date for completion: March 31, 2016

Facility response: The facility currently has a Medical Center Memorandum (MCM), Cleaning and Disinfection of Non Critical Patient Care Equipment (658-00-20), outlining procedures for cleaning and disinfection of non-critical RME that is posted in all clinical areas. Managers will reeducate staff by January 15, 2016 concerning MCM 658-00-20 and will submit attendance records to the Infection Control Committee for monthly tracking until closure. Environmental Management Service and Nursing Service will add the review of adequate supplies to the collaborative environmental monthly rounds ("clean sweep") and will ensure that adequate supplies are in place with par levels adjusted through Logistics as necessary. Nurse Managers will document the adequacy of supplies through "clean sweep" monitoring and report to the Nurse Executive Council monthly until closure.

Recommendation 6. We recommended that facility managers ensure medications awaiting destruction are stored separately from medications available for administration and monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: The following corrective actions were implemented as of September 25, 2015:

a. The Pharmacy technician staff was educated regarding proper removal of expired product and sequestration in designated destruction holding areas in the pharmacy.
b. Monthly monitoring was initiated by the Pharmacy to ensure that medications awaiting destruction are stored separately from medications available for administration.

Monitoring results will be reported through the P&T Committee with a goal of no less than 90% sustained for a period of three months.

Recommendation 7. We recommended that facility managers ensure patient-specific insulin vials distributed to units are consistently labeled with correct expiration dates and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: The following corrective actions were implemented by September 29, 2015:

a. On September 29, 2015, the Pharmacy and Therapeutics Committee established a standard insulin vial expiration dating of 28 days for all inpatient dispensed insulin vials.
b. The Pharmacy revised the service SOP for patient specific vials of insulin and reviewed it with technician and pharmacist staff to ensure compliance with 28 day expiration dating.
c. Initiated random monthly monitoring by pharmacist supervisors to verify dating policy compliance.

Monitoring results will be reported through the P&T Committee with a goal of no less than 90% sustained for a period of three months.

Recommendation 8. We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.

Concur

Target date for completion: March 1, 2016

Facility response: Social Work Service (SWS) has provided Advanced Directive guidance to clinical staff regarding how to correctly post patients' AD status. SWS will monitor compliance monthly through random chart audits of 50 records and report through service performance improvement to the Executive leadership Board.

Monitoring will continue until 90% compliance is achieved for at least three consecutive months.

Recommendation 9. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: March 1, 2016

Facility response: The process alerting Social Workers when an inpatient requests additional AD information was communicated to all inpatient Social Workers and Nursing staff during the month of October 2015. SWS will monitor compliance monthly through random chart audits of 50 records and report through service performance improvement to the Executive leadership Board. Monitoring will continue until 90% compliance is achieved until closure.

Recommendation 10. We recommended that facility managers ensure that surgical intensive care unit nurses have 12-lead electrocardiogram and post-anesthesia care competency assessment and validation included in their competency checklists.

Concur

Target date for completion: April 30, 2016

Facility response: All Surgical Care ICU nurses completed 12 lead electrocardiogram competency assessments in their orientation and again in 2015. This competency is now included for annual competency assessment and validation.

A Post Anesthesia Care Competency checklist is completed in orientation and has been included as part of the Surgical Complexity Competencies to be assessed and validated by ICU staff annually. Annual EKG and Surgical Care Complexity competencies will be monitored monthly by the ICU Nurse Manager and reported to the Nurse Executive Council until closure. The VA's electronic Talent Management System (TMS) will be used for tracking.

Recommendation 11. We recommended that the facility ensure that initial clinician emergency airway management competency assessment includes all required subject matter content elements and evidence of a completed written test and that facility managers monitor compliance.

Concur

Target date for completion: February 29, 2016

Facility response: All initial clinician emergency airway management competency assessments now include all required subject matter content elements and evidence of a completed written test.

The Chief of Anesthesia has oversight of EAM program competencies and collaborates with Service Chiefs to monitor compliance for providers in their respective services through the biennial Credentialing and Privileging process. The Respiratory Section Chief monitors EAM competencies for Respiratory Therapists through tracking of VA's electronic Talent Management System (TMS). The Chief of Anesthesia will report staff compliance status monthly to MEB until closure and to Surgical Operative Invasive Procedure Committee quarterly thereafter.

Recommendation 12. We recommended that the facility ensure that initial clinician emergency airway management competency assessment includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and evidence of successful demonstration of all required procedural skills on patients and that facility managers monitor compliance.

Concur

Target date for completion: February 29, 2016

Facility response: Initial clinician emergency airway management competency assessments now include evidence of successful demonstration of all required procedural skills on airway simulators and evidence of all required procedural skills on patients.

The Chief of Anesthesia has oversight of EAM program competencies and collaborates with Service Chiefs to monitor compliance for providers in their respective services through the biennial Credentialing and Privileging process. The Respiratory Section Chief monitors EAM competencies for Respiratory Therapists through tracking of VA's electronic Talent Management System (TMS). The Chief of Anesthesia will report staff compliance status monthly to MEB until closure and to the Surgical Operative Invasive Procedure Committee quarterly thereafter.

Recommendation 13. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2016

Facility response: Clinician reassessment for continued emergency airway management competency now includes reviews of clinician-specific emergency airway management data and documentation of successful demonstration of all required

procedural skills on airway simulators. The Chief of Anesthesia has oversight of EAM program competencies and collaborates with Service Chiefs to monitor clinician compliance through a standardized documentation process. The Chief of Anesthesia will report compliance status monthly to MEB until closure and to the Surgical and Invasive Procedure Committee periodically thereafter. The VA's electronic Talent Management System (TMS) will be used for tracking.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Bob Goodlatte, Morgan Griffith

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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[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 Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[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.