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

August 1, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	W.G. (Bill) Hefner VA Medical Center
FY	fiscal year
MH	mental health
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SPS	Sterile Processing Service
VHA	Veterans Health Administration

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Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the W.G. (Bill) Hefner VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and Mental Health Residential Rehabilitation Treatment Program. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of March 27, 2017, and identified certain system weaknesses in utilization management, general safety, environmental cleanliness, anticoagulation patient education, transfer documentation, glucometer quality control testing, moderate sedation processes and documentation, community nursing home oversight and clinical visits, disruptive/violent behavior documentation and employee training, and Mental Health Residential Rehabilitation Treatment Program inspections and environmental safety.

Review Impact: As a result of the findings, we could not gain reasonable assurance that the facility:

1. Has effective documentation, communication, and quality improvement processes for decisions involving utilization management
2. Maintains a clean environment of care in the Emergency Department and has a policy and procedure for the reprocessing of reusable medical equipment
3. Maintains a safe environment of care with consistent fire drills, labels food items in the nourishment refrigerators, and secures chemicals in the hemodialysis unit
4. Provides effective anticoagulation therapy management patient education
5. Has a safe inter-facility transfer process
6. Performs quality control testing on glucometers
7. Provides safe moderate sedation care
8. Provides effective community nursing home oversight
9. Has an effective process for the management of disruptive/violent behavior incidents
10. Maintains a safe Mental Health Residential Rehabilitation Treatment Program environment

Recommendations: We made recommendations in nine review areas.

Quality, Safety, and Value – Ensure that:
- Physician Utilization Management Advisors consistently document decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:
- All health care occupancy buildings conduct at least one fire drill per shift per quarter.
- Emergency Department air conditioner and steam/heat ventilation grills are clean.
- Food items in patient nourishment refrigerators are labeled.
- A policy for cleaning, disinfecting, and sterilizing reusable medical equipment is implemented.
- Standard operating procedures for the colonoscope, esophagogastroduodenoscope, and duodenoscope are consistent with the manufacturer's instructions for use.
- Hemodialysis unit employees secure chemicals when not in use.

Medication Management: Anticoagulation Therapy – Ensure that:
- Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- Providers consistently complete VA Form 10-2649A, Inter-Facility Transfer Form, or use a properly templated inter-facility transfer note template for patients transferred out of the facility and consistently include required elements.
- Transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature.
- Sending nurses document transfer assessments/notes for patients transferred out of the facility.
- For emergent transfers, provider transfer notes include a statement of patient stability for transfer.

Diagnostic Care: Point-of-Care Testing – Ensure that:
- Employees perform quality control on glucometers in accordance with the facility's policy/standard operating procedure and the manufacturer's recommendations.

Moderate Sedation – Ensure that:
- The history and physical and/or pre-sedation assessment includes a history of previous adverse experience with sedation and anesthesia.
- Patients are re-evaluated immediately before moderate sedation for changes since the prior assessment.
- Patients are notified of changes in who is performing the moderate sedation procedure and that this is documented in the electronic health record.
- Clinical employees discharge outpatients from the recovery area with orders given by a qualified provider or according to criteria approved by moderate sedation clinical leaders.

Community Nursing Home Oversight – Ensure that:

- The facility integrates the community nursing home program into its quality improvement program.
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight.

Management of Disruptive/Violent Behavior – Ensure that:

- The Disruptive Behavior Committee discusses patients' disruptive or violent behavior and that a progress note is entered into the patients' electronic health records.
- Clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program – Ensure that:

- Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document monthly self-inspections, every 2-hour rounds of all public spaces, daily bed checks, and daily resident room inspections for unsecured medications.
- The Substance Abuse Residential Rehabilitation Treatment Program unit's non-main entry door is alarmed at all times.

Comments

The Acting Veterans Integrated Service Network Director and Interim Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 43–53, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

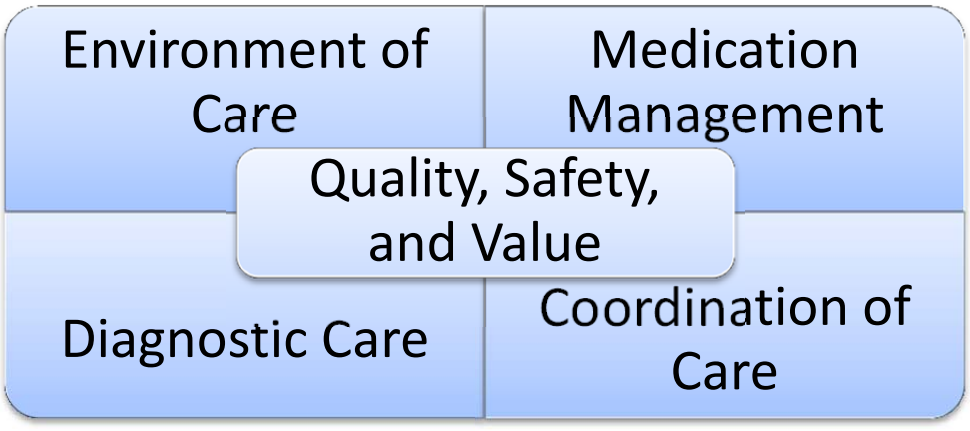
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV; EOC; Medication Management; Coordination of Care; and Diagnostic Care.

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, Management of Disruptive/Violent Behavior, and MH RRTP—and follows up on recommendations from the previous CAP and Community Based Outpatient Clinic and PC Clinic reviews. Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people who enter the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] "Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety."[12]

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.[18] VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[19]

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
[19] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

We also evaluated four additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through March 31, 2017, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina,* Report No. 14-00687-155, May 20, 2014) and community based outpatient clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina,* Report No. 14-00242-160, May 27, 2014).

We presented crime awareness briefings for 71 employees. These briefings covered procedures for reporting suspected criminal activity to 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 581 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 OIG to monitor until the facility implements corrective actions. Issues and concerns outside the scope of the CAP review came to our attention and were referred for further review separate from this report.

Reported Accomplishments

Accelerated Issuance of Pre-Determined Prosthetics Items in the Primary Care Setting

In February 2016, the facility identified a need to improve the issuance of pre-determined prosthetics items in the PC setting. The development of a standardized process allowed the facility to stock and issue pre-determined prosthetic items in all PC settings. Average wait times for simple items such as compression stockings, ankle braces, and crutches decreased from 48 days to same day issuance. Kinesiotherapy access was improved by decreasing consultations from 61 to 14 days. Concurrently, beneficiary travel cost was reduced by $203,550 from March 2016 to December 2016.

Enhanced Operating Room Efficiency

In September 2015, the facility started a surgical flow improvement initiative with the goal of reducing operating room turnover time from 50 minutes to 30 minutes by the end of the year. For quarter 1 of FY 2016, the operating room turnover rate was decreased to 27.3 minutes. In addition, several improvements were made, which included developing a pre-operative communication board, centrally locating operating room supplies, implementing turnover kits, and providing Cisco phones to expedite the communication between Environmental Management Service and operating room employees.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For 54 of 280 cases (19 percent) referred to Physician Utilization Management Advisors January 11–March 13, 2017, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database. This resulted in less data for the facility to use to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes.	**1.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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 SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the medical/surgical/telemetry, intensive care, hemodialysis, and locked MH units (8-1 and 8-2); the Emergency Department; hospice; the community living center (units 42-1B and 42-1C); the women's clinic, and the South Charlotte VA Clinic. We also inspected the SPS areas at the main facility and the South Charlotte VA Clinic. Additionally, we reviewed relevant documents and 18 employee training records, and we interviewed 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.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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 procedure for cleaning equipment between patients.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Fire drill documentation for health care occupancy buildings for quarters 3 and 4 of FY 2016 reviewed: • All applicable buildings did not have at least one fire drill per shift per quarter.	**2.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• In the Emergency Department, 11 air conditioner ventilation grills and 3 wall steam/heat ventilation grills were dusty. • Two of eight patient nourishment refrigerators contained several unlabeled food items.	**3.** We recommended that facility managers ensure air conditioner and steam/heat ventilation grills in the Emergency Department are clean and monitor compliance. **4.** We recommended that facility managers ensure refrigerators in patient nourishment kitchens do not contain unlabeled food items and monitor compliance.

NM	Areas Reviewed for SPS	Findings	Recommendations
X	The facility had a policy for cleaning, disinfecting, and sterilizing RME.	• The facility did not have a policy for cleaning, disinfecting, and sterilizing RME.	**5.** We recommended that the facility implement a policy for cleaning, disinfecting, and sterilizing reusable medical equipment.
X	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.	• Standard operating procedures for the colonoscope, esophagogastroduodenoscope, and duodenoscope were not consistent with the manufacturers' instructions for use.	**6.** We recommended that facility managers ensure standard operating procedures for the colonoscope, esophagogastroduodenoscope, and duodenoscope are consistent with the manufacturers' instructions for use.
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year		
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		

NM	Areas Reviewed for the Hemodialysis Unit	Findings	Recommendations
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
X	The facility met environmental safety requirements on the hemodialysis unit.	• We observed chemicals stored in an unlocked supply cart in an area accessible to patients.	**7.** We recommended that hemodialysis unit employees secure chemicals when not in use and that the hemodialysis unit manager monitors compliance.
	The facility met infection prevention requirements on the hemodialysis unit.		
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[20] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of 13 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[20] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
X	Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients.	• Six of the 34 EHRs (18 percent) did not contain evidence that patients received education specific to the newly prescribed anticoagulant.	**8.** We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.		

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed	• Seventeen of the 49 EHRs (35 percent) did not contain VA Form 10-2649A or the correct inter-facility transfer/progress notes in transfer documentation. • Provider transfer documentation did not include: o Date of transfer in 8 of 49 EHRs (16 percent) o Documentation of patient or surrogate informed consent in 33 of 49 EHRs (67 percent) o Documentation of medical and behavioral stability in 11 of 49 EHRs (22 percent) o Identification of transferring and receiving provider or designee in 43 of 49 EHRs (88 percent) o Details of the reason for transfer or proposed level of care needed in 7 of 49 EHRs (14 percent)	**9.** We recommended that providers consistently complete VA form 10-2649A or use a properly templated inter-facility transfer note template for patients transferred out of the facility and that facility managers monitor compliance **10.** We recommended that for patients transferred out of the facility, providers consistently include date of transfer, documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in VA Form 10-2649A, Inter-Facility Transfer Form, and that facility managers monitor compliance.
X	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note	• In 9 of the 10 applicable EHRs, transfer notes written by acceptable designees did not document staff/attending physician approval and did not contain a staff/attending physician countersignature in order to document that the decision to transfer was made by a credentialed provider.	**11.** We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature and monitor compliance.
X	When the facility transferred patients out, sending nurses documented transfer assessments/notes.	• Eleven of the 49 EHRs (22 percent) did not contain sending nurses' transfer assessments/notes.	**12.** We recommended that sending nurses document transfer assessments/notes for patients transferred out of the facility and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity	• In 6 of the 31 applicable EHRs (19 percent), provider transfer notes did not document patient stability for transfer.	**13.** We recommended that facility managers ensure that for emergent transfers, provider transfer notes include a statement of patient stability for transfer and that facility managers monitor compliance.
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		

Diagnostic Care: Point-of Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and prothrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[21]

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessments of 10 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of unit 42-2B, the Emergency Department, pre-/post-anesthesia, radiology, endoscopy, and the intensive care unit at the main facility; the South Charlotte VA Clinic; the Kanapolis clinic; the Lake Wylie clinic; the Latta Park clinic; and the endoscopy suite to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		

[21] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
X	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.	• In 5 of 11 units/clinics inspected, employees did not perform quality control testing on the glucometer in accordance with the facility's policy/standard operating procedure and manufacturer's recommendations.	**14.** We recommended that employees perform quality control on glucometers in accordance with the facility's policy/standard operating procedure and the manufacturer's recommendations and that facility managers monitor compliance.
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[22] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[23] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents and interviewed key employees. We also inspected the gastroenterology, cardiology, interventional radiology, intensive care unit, and Emergency Department procedure rooms/areas at the main facility; the gastroenterology and cardiology procedure rooms/areas at the South Charlotte VA Clinic; and the cardiology procedure room/area at the Kernersville VA Clinic to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 46 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[22] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[23] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.	• In 13 of the 46 EHRs (28 percent), providers did not include history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment.	**15.** We recommended that providers include history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment and that facility managers monitor compliance.
X	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.	• Providers did not document patient re-evaluations immediately before moderate sedation in any of the 46 EHRs.	**16.** We recommended that providers re-evaluate patients immediately before moderate sedation for changes since the prior assessment and that facility managers monitor compliance.
X	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.	• In all six EHRs where the name of the provider listed on the informed consent did not match that of the provider(s) who performed the procedure, there was no documentation that the provider informed the patient of the change.	**17.** We recommended that providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and that facility managers monitor compliance.
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
X	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.	• In 7 of 45 outpatient EHRs (16 percent), there was no evidence that clinical employees discharged outpatients from the recovery area appropriately.	**18.** We recommended that clinical employees discharge outpatients from the recovery area with orders given by a qualified provider or according to criteria approved by moderate sedation clinical leaders and that clinical managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[24] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 32 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
X	The facility integrated the CNH program into its quality improvement program.	• The minutes of the executive-level committee that evaluates quality improvement data did not contain evidence of CNH program integration.	**19.** We recommended that the facility integrate the community nursing home program into its quality improvement program.
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		

[24] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Three of the 27 applicable EHRs did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. All three patients resided in the Old Knox Commons at the Villages of Mecklenburg facility.	**20.** We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 49 randomly selected patients who exhibited disruptive or violent behavior, 3 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period July 1, 2015 through June 30, 2016, and the training records of 38 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system		
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• There was no evidence of Disruptive Behavior Committee/Board discussion associated with Patient Record Flag placement in any of the eight applicable EHRs. • There was no evidence that clinicians informed the patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement in any of the 13 applicable EHRs.	**21.** We recommended that facility managers ensure Disruptive Behavior Committee discussion of patients' disruptive or violent behavior and entry of a progress note into the patients' electronic health records. **22.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• In 18 of the 38 employee training records (47 percent), there was no documentation of Level I training within 90 days of hire. • In 32 of the 38 employee training records (84 percent), there was no documentation of the training required for their assigned risk area within 90 days of hire.	**23.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure training is documented in employee training records, and monitor compliance.

Mental Health Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility's MH RRTPs (more commonly referred to as domiciliary or residential treatment programs) complied with selected EOC requirements. The Domiciliary Care for Homeless Veterans Program was established through legislation in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. In 1995, VA established the Psychosocial RRTP bed level of care. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary RRTP became fully integrated with other RRTPs of the Office of MH Services.[i]

We reviewed relevant documents, inspected the Substance Abuse RRTP, and interviewed key 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 not applicable.

Checklist 9. MH RRTP Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of self-inspection documentation requested: • We did not find documentation of monthly self-inspections on the Substance Abuse RRTP from July through December 2016.	**24.** We recommended that Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document monthly self-inspections and that program managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	• For the 7-day period, March 19–25, 2016, Substance Abuse RRTP employees did not consistently conduct and document every 2-hour rounds of all public spaces and daily bed checks. • For the 14-day period, March 12–25, 2016, Substance Abuse RRTP employees did not consistently conduct and document daily resident room inspections for unsecured medications.	**25.** We recommended that Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document every 2-hour rounds of all public spaces, daily bed checks, and daily resident room inspections for unsecured medications and that program managers monitor compliance.
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
X	The MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• The Substance Abuse RRTP unit door not considered the main point of entry was locked to the outside but not alarmed.	**26.** We recommended that facility managers ensure the Substance Abuse Residential Rehabilitation Treatment Program unit's non-main entry door is alarmed at all times and that program managers monitor compliance.
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and had signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Note: NA=not applicable

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Salisbury (659) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	6
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$566.3
Number of:	
• **Unique Patients**	88,243
• **Outpatient Visits**	838,970
• **Unique Employees**[25]	2,032
Type and Number of Operating Beds:	
• **Acute**	44
• **MH**	63
• **Community Living Center**	109
• **Domiciliary**	35
Average Daily Census:	
• **Acute**	32
• **MH**	44
• **Community Living Center**	100
• **Domiciliary**	29

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[25] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[26]

The VA outpatient clinics in the communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[27] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[28] Provided	Diagnostic Services[29] Provided	Ancillary Services[30] Provided
Kernersville, NC	659BY	48,056	17,524	Allergy Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Blind Rehab Rehab Physician ENT Eye General Surgery Plastic Podiatry	Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Weight Management

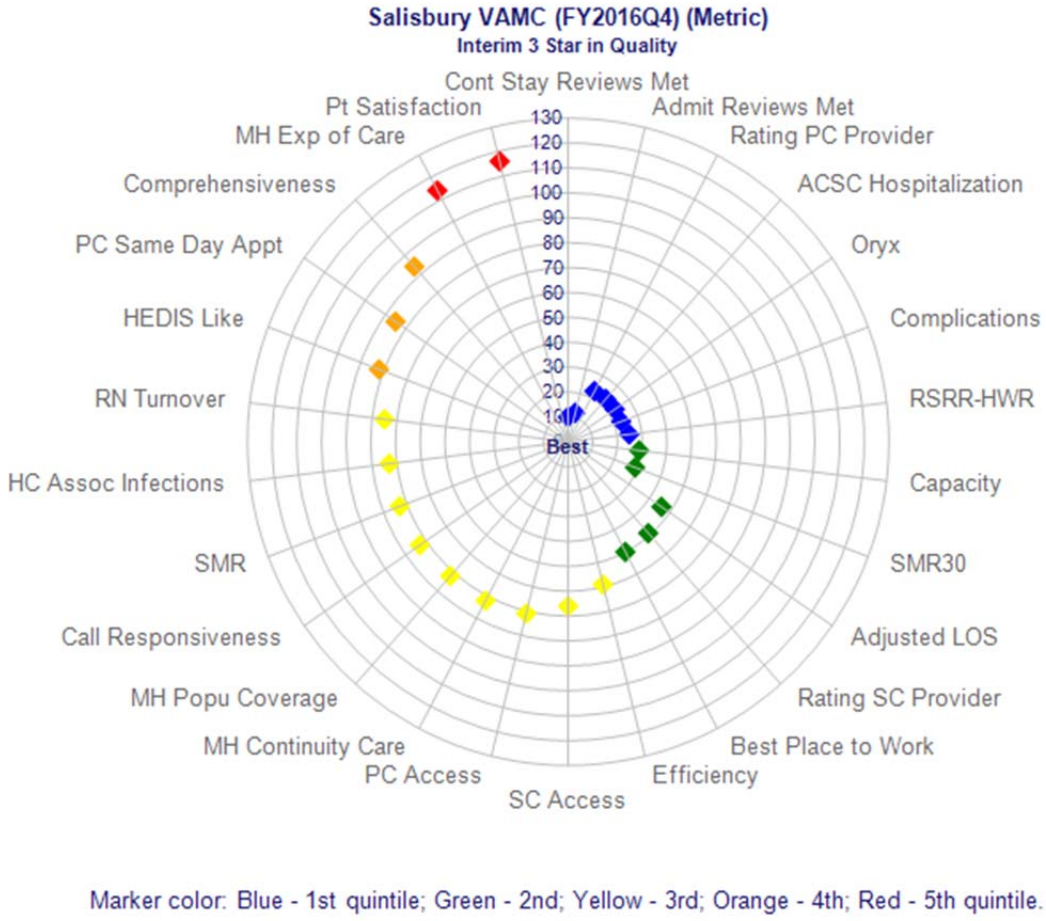
[26] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Hickory, NC (659GB); Winston-Salem, NC (659GC); and Charlotte, NC (659QA), as they were permanently deactivated on 10/31/2015, 7/31/2016, and 7/31/2016, respectively.
[27] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[28] Specialty care services refer to non-PC and non-MH services provided by a physician.
[29] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[30] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Charlotte, NC	659BZ	20,883	10,448	Allergy Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Blind Rehab Rehab Physician Eye General Surgery Plastic Podiatry Urology	EKG EMG Radiology	Nutrition Pharmacy Prosthetics Weight Management Dental
Charlotte, NC	659GA	36,190	10,796	Cardiology Dermatology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Blind Rehab Eye General Surgery Plastic Podiatry Urology	EKG EMG Laboratory & Pathology Nuclear Medicine Radiology	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

Strategic Analytics for Improvement and Learning (SAIL)[31]

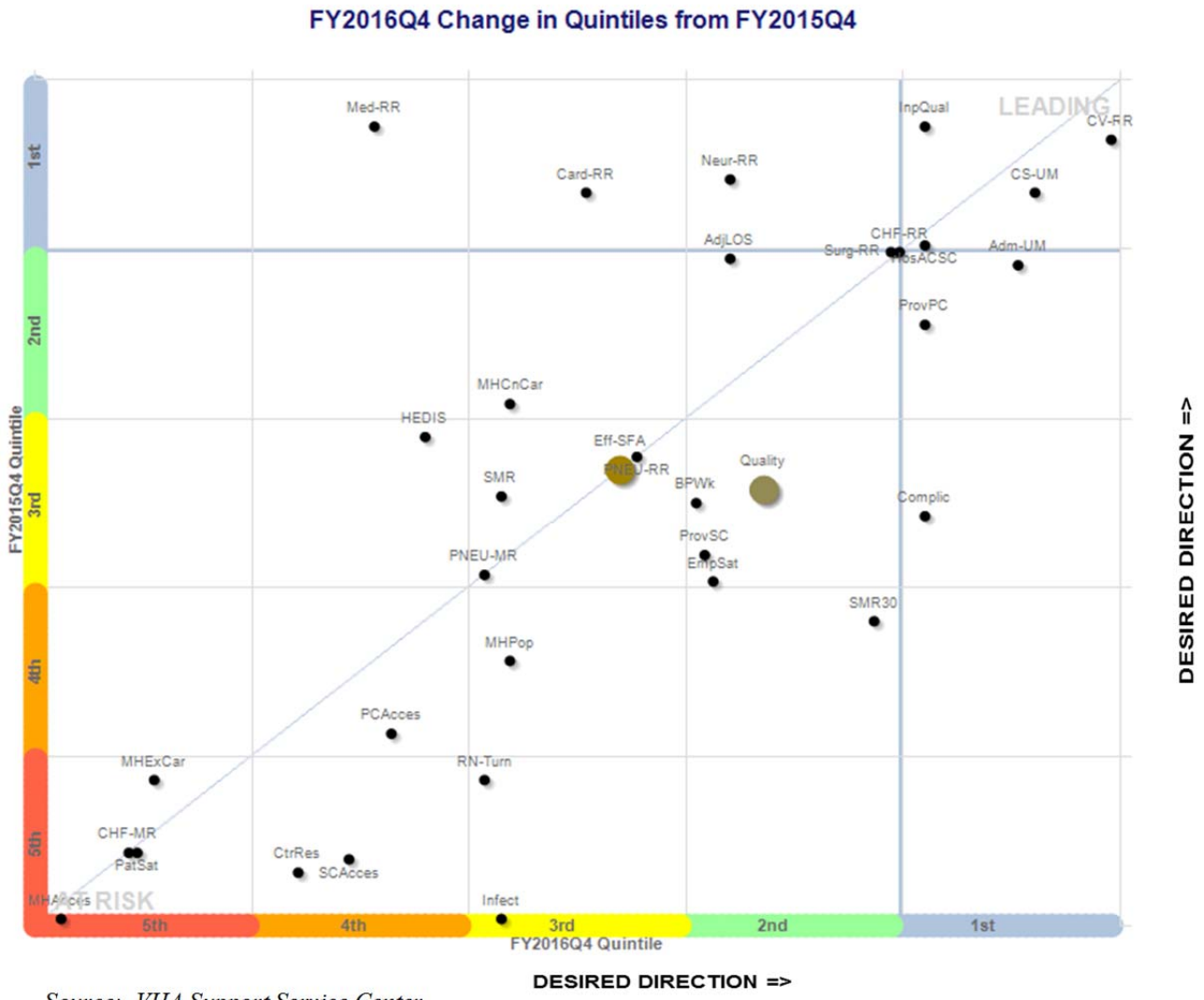


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[31] 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.

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[j]

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
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower 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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
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
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	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

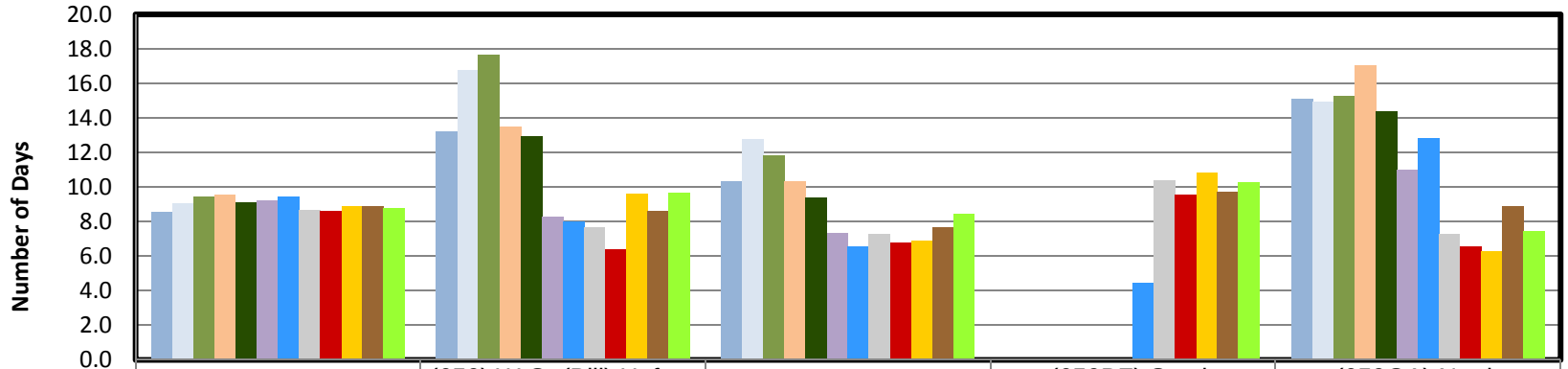
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	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-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	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
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower 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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

FY 2016 New PC Patient Average Wait Time in Days

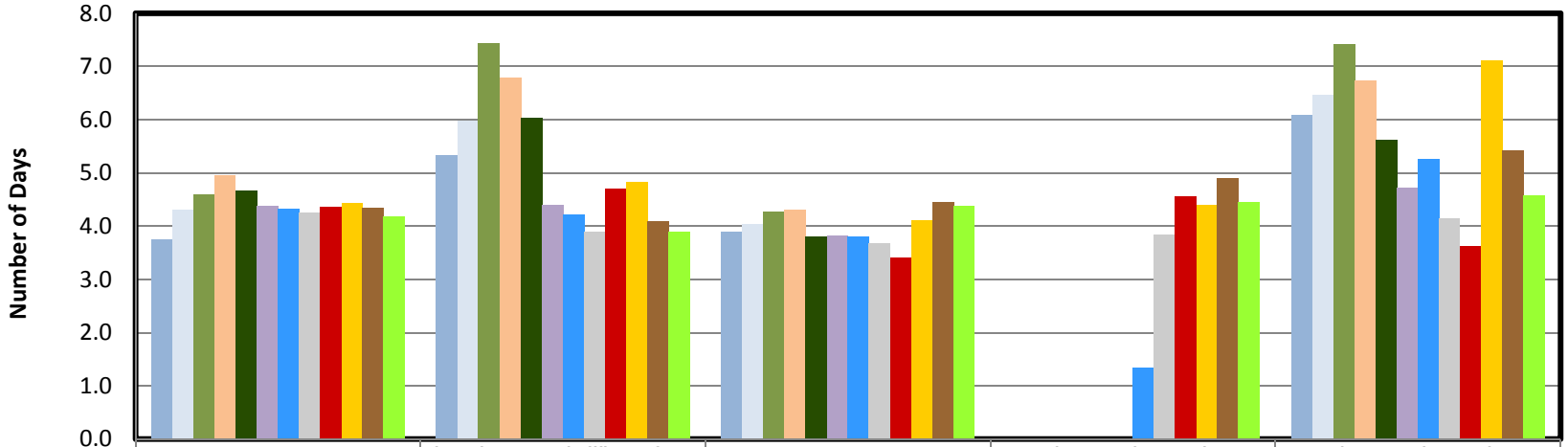


	VHA Total	(659) W.G. (Bill) Hefner Salisbury VAMC	(659BY) Kernersville	(659BZ) South Charlotte	(659GA) North Charlotte
OCT-FY16	8.6	13.2	10.3		15.1
NOV-FY16	9.1	16.8	12.8		14.9
DEC-FY16	9.5	17.7	11.8		15.3
JAN-FY16	9.6	13.5	10.3		17.0
FEB-FY16	9.1	13.0	9.4		14.4
MAR-FY16	9.2	8.3	7.4		11.0
APR-FY16	9.5	8.0	6.6	4.4	12.9
MAY-FY16	8.7	7.7	7.3	10.4	7.3
JUN-FY16	8.6	6.4	6.8	9.6	6.6
JUL-FY16	8.9	9.6	6.9	10.8	6.3
AUG-FY16	8.9	8.6	7.7	9.7	8.9
SEP-FY16	8.8	9.7	8.5	10.3	7.4

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[k]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.* Blank cells indicate the absence of reported data.

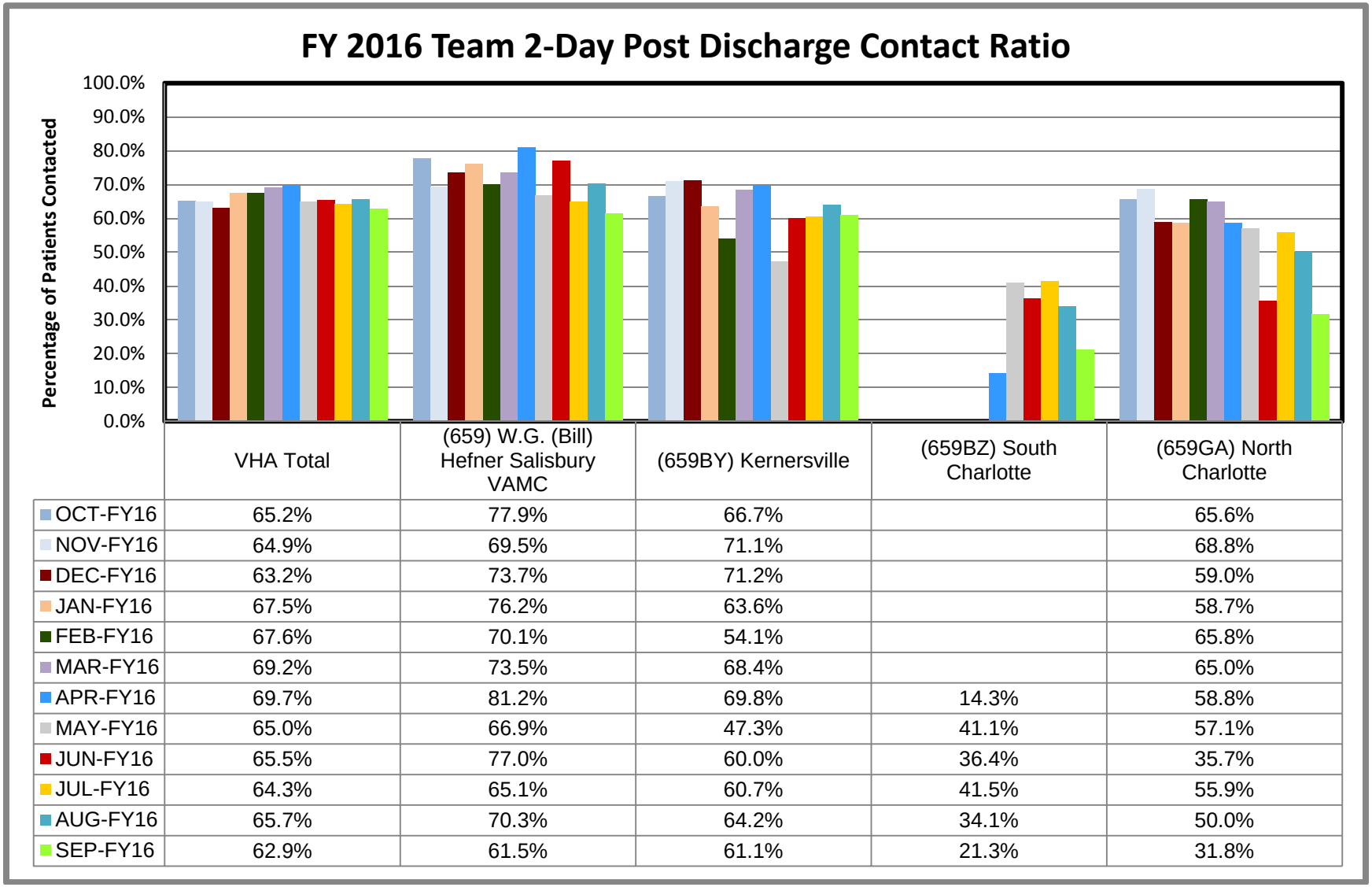


	VHA Total	(659) W.G. (Bill) Hefner Salisbury VAMC	(659BY) Kernersville	(659BZ) South Charlotte	(659GA) North Charlotte
OCT-FY16	3.8	5.3	3.9		6.1
NOV-FY16	4.3	6.0	4.0		6.5
DEC-FY16	4.6	7.4	4.3		7.4
JAN-FY16	4.9	6.8	4.3		6.7
FEB-FY16	4.7	6.0	3.8		5.6
MAR-FY16	4.4	4.4	3.8		4.7
APR-FY16	4.3	4.2	3.8	1.3	5.3
MAY-FY16	4.3	3.9	3.7	3.8	4.1
JUN-FY16	4.4	4.7	3.4	4.6	3.6
JUL-FY16	4.4	4.8	4.1	4.4	7.1
AUG-FY16	4.3	4.1	4.4	4.9	5.4
SEP-FY16	4.2	3.9	4.4	4.4	4.6

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Blank cells indicate the absence of reported data.

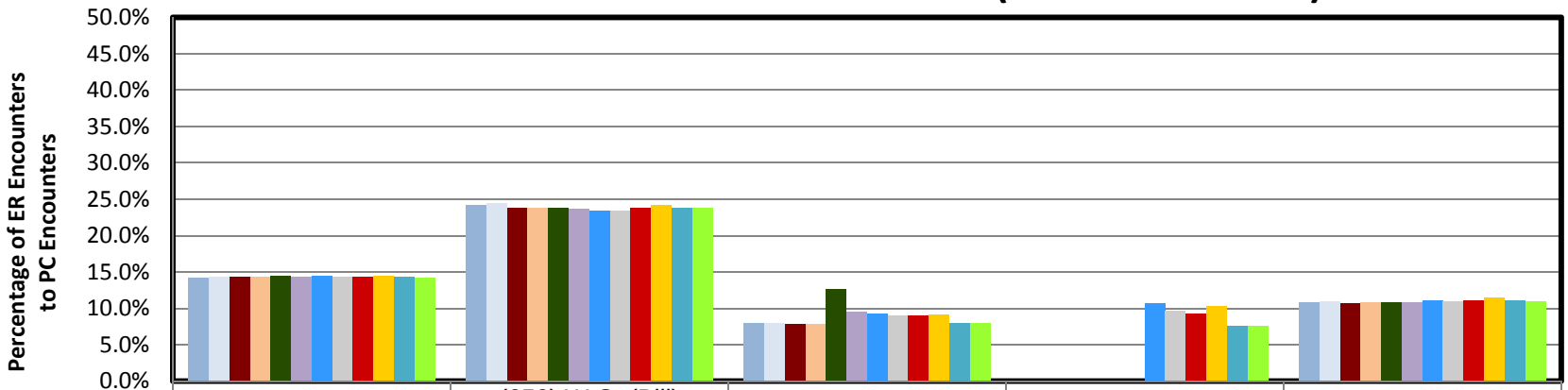


	VHA Total	(659) W.G. (Bill) Hefner Salisbury VAMC	(659BY) Kernersville	(659BZ) South Charlotte	(659GA) North Charlotte
OCT-FY16	65.2%	77.9%	66.7%		65.6%
NOV-FY16	64.9%	69.5%	71.1%		68.8%
DEC-FY16	63.2%	73.7%	71.2%		59.0%
JAN-FY16	67.5%	76.2%	63.6%		58.7%
FEB-FY16	67.6%	70.1%	54.1%		65.8%
MAR-FY16	69.2%	73.5%	68.4%		65.0%
APR-FY16	69.7%	81.2%	69.8%	14.3%	58.8%
MAY-FY16	65.0%	66.9%	47.3%	41.1%	57.1%
JUN-FY16	65.5%	77.0%	60.0%	36.4%	35.7%
JUL-FY16	64.3%	65.1%	60.7%	41.5%	55.9%
AUG-FY16	65.7%	70.3%	64.2%	34.1%	50.0%
SEP-FY16	62.9%	61.5%	61.1%	21.3%	31.8%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Blank cells indicate the absence of reported data.



	VHA Total	(659) W.G. (Bill) Hefner Salisbury VAMC	(659BY) Kernersville	(659BZ) South Charlotte	(659GA) North Charlotte
OCT-FY16	14.3%	24.3%	7.9%		10.8%
NOV-FY16	14.4%	24.4%	8.0%		11.0%
DEC-FY16	14.3%	23.9%	7.9%		10.7%
JAN-FY16	14.3%	23.8%	7.8%		10.9%
FEB-FY16	14.4%	23.8%	12.7%		10.8%
MAR-FY16	14.4%	23.7%	9.6%		10.8%
APR-FY16	14.4%	23.4%	9.3%	10.7%	11.1%
MAY-FY16	14.4%	23.4%	9.1%	9.6%	11.0%
JUN-FY16	14.4%	23.8%	9.0%	9.3%	11.1%
JUL-FY16	14.4%	24.2%	9.1%	10.3%	11.5%
AUG-FY16	14.3%	23.8%	7.9%	7.6%	11.1%
SEP-FY16	14.2%	23.8%	7.9%	7.6%	10.9%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP. Blank cells indicate the absence of reported data.

Prior OIG Reports
April 1, 2014 through April 1, 2017

Facility Reports

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6
3/2/2017 | *16-02618-424* | *Summary* | *Report*

Healthcare Inspection – Mental Health-Related Concerns, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
11/9/2016 | *15-05180-75* | *Summary* | *Report*

Review of an Alleged Radiology Exam Backlog at the W.G. (Bill) Hefner VAMC in Salisbury, NC
10/4/2016 | *14-02890-425* | *Summary* | *Report*

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | *15-01579-457* | *Summary* | *Report*

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | *15-01297-368* | *Summary* | *Report*

Healthcare Inspection – Inadequate Follow-Up of an Abnormal Imaging Result, Charlotte Community Based Outpatient Clinic, Charlotte, North Carolina
3/9/2015 | *15-00190-146* | *Summary* | *Report*

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015 | *14-04194-118* | *Summary* | *Report*

Healthcare Inspection – Out of Operating Room Airway Management Concerns, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
9/30/2014 | *13-04005-296* | *Summary* | *Report*

Appendix E

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: June 14, 2017

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

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

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the draft report of the office of the Inspector General and I concur with the findings, recommendations, and submitted action plans. Please feel free to contact me for any questions or comments.

MARK E. SHELHORSE, MD
Acting Network Director, VISN 6

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 7, 2017

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

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

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

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

Subbarao V. Pemmaraju, MD, MHA
Interim Director

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 Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2017

Facility response: Physician Utilization Management Advisors were educated regarding the expectation that 100 percent of Physician Utilization Management Advisor's decisions be documented in the National Utilization Management Integration database. Since April 2017, providers have been 100 percent compliant with documenting their decisions in the National Utilization Management Integrated database.

Recommendation 2. We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: The drill for the Substance Abuse Residential Rehabilitation Treatment Program unit was inadvertently set up in the tracking log to be completed yearly therefore the quarterly drills were missed for that unit. The tracking log was revised to ensure the drills are completed on a quarterly basis. Compliance with quarterly fire drills will be monitored by the Safety Manager and reported the Environment of Care Committee for oversight.

Recommendation 3. We recommended that facility managers ensure air conditioner and steam/heat ventilation grills in the Emergency Department are clean and monitor compliance.

Concur

Target date for completion: August 30, 2017

Facility response: The Environmental Services staff cleaned the ventilation grills in the Emergency Department. Environmental Services in collaboration with Engineering will

ensure the ventilation grills are clean. The Environmental Services supervisor will check the ventilation grills at least monthly to ensure they are cleaned.

Recommendation 4. We recommended that facility managers ensure refrigerators in patient nourishment kitchens do not contain unlabeled food items and monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: Nursing staff will be reminded that items placed in the nourishment refrigerators must be labeled as required. The charge nurse will check the refrigerators each shift to ensure there are no unlabeled items in the refrigerator. Compliance will be reported monthly to the Nurse Executive Board for oversight.

Recommendation 5. We recommended that the facility implement a policy for cleaning, disinfecting, and sterilizing reusable medical equipment.

Concur

Target date for completion: July 15, 2017

Facility response: The facility had a Standard Operating Procedure for reprocessing critical and semi-critical reusable medical equipment. The Standard Operating Procedure was rescinded and a Medical Center Memorandum was developed to include a more robust procedure for cleaning, disinfecting, and sterilizing reusable medical equipment.

Recommendation 6. We recommended that facility managers ensure standard operating procedures for the colonoscope, esophagogastroduodenoscope, and duodenoscope are consistent with the manufacturers' instructions for use.

Concur

Target date for completion: June 30, 2017

Facility response: The Standard Operating Procedures for the colonoscope, esophagogastroduodenoscope, and duodenoscope were reviewed and revised to ensure they are consistent with manufacturer's instructions for use.

Recommendation 7. We recommended that hemodialysis unit employees secure chemicals when not in use and that the hemodialysis unit manager monitors compliance.

Concur

Target date for completion: June 30, 2017

Facility response: The impatient hemodialysis unit consists of one room that is consistently locked. Patients are accompanied by a dedicated dialysis nurse when in the room. The patient is never left alone in the room. The chemicals that were stored on the shelf in the room were relocated on March 28, 2017, the same day discovered during the survey. All chemicals are now located in the storage room adjacent to the dialysis room. The Nurse Manager will monitor the room weekly to ensure no chemicals are stored in the room.

Recommendation 8. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2017

Facility response: Providers/Nurses were reminded to provide specific education to all patients who are prescribed new orders for anticoagulant medications. A template will be created for the inpatient medical/surgical nursing discharge note for specific documentation of education for patients who are discharged on post-surgical prophylactic anticoagulant therapy. The Office of Performance and Quality will monitor compliance with education requirements.

Recommendation 9. We recommended that providers consistently complete VA Form 10-2649A or use a properly templated inter-facility transfer note template for patients transferred out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2017

Facility response: The template was revised to include all required elements from Form 10-2649A. The Office of Performance and Quality will monitor compliance with appropriately completing the inter-facility transfer note.

Recommendation 10. We recommended that for patients transferred out of the facility, providers consistently include date of transfer, documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in VA Form 10-2649A, Inter-Facility Transfer Form, and that facility managers monitor compliance.

Concur

Target date for completion: August 30, 2017

Facility response: The transfer note template was revised to include all required elements in Form 10-2649A. The date of transfer, documentation of medical and

behavioral stability, and identification of transferring and receiving provider or designee are now required fields. Documentation of patient or surrogate informed consent is completed via iMedConsent™. Completion of the iMedConsent™ is verified using the transfer checklist and reviewed during the pre-transfer huddle. The Office of Performance and Quality will monitor compliance with appropriately completing the inter-facility transfer note (with all required elements) and the consent to transfer.

Recommendation 11. We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature and monitor compliance.

Concur

Target date for completion: August 30, 2017

Facility response: Providers were reminded of requirements to include a countersignature as appropriate for transfers. The Office of Performance and Quality will monitor compliance with appropriately including an attending physician countersignature.

Recommendation 12. We recommended that sending nurses document transfer assessments/notes for patients transferred out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2017

Facility response: Nursing staff were reminded of the requirement to complete a nursing transfer note for all patient transfers. The nursing transfer note was updated to include required elements. Compliance will be monitored by the Office of Performance and Quality.

Recommendation 13. We recommended that facility managers ensure that for emergent transfers, provider transfer notes include a statement of patient stability for transfer and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2017

Facility response: Statement of patient stability for transfer is included in the revised transfer template. The Office of Performance and Quality will monitor compliance with documentation of patient stability for an emergent transfer.

Recommendation 14. We recommended that employees perform quality control on glucometers in accordance with the facility's policy/standard operating procedure and the manufacturer's recommendations and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2017

Facility response: The facility policy was updated to ensure the quality control checks are completed as required. In addition, the meter will lock all users out of patient testing until the controls are completed. The Ancillary Testing Coordinator will monitor compliance.

Recommendation 15. We recommended that providers include history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: Providers were reeducated on the requirements to include history of previous adverse experience with sedation and anesthesia in the pre-sedation assessment. Computerized Patient Record System templates are being revised to include all required elements for areas that were non-compliant. The Office of Performance and Quality will monitor compliance to ensure history of previous adverse experience with sedation is included in the pre-sedation assessment.

Recommendation 16. We recommended that providers re-evaluate patients immediately before moderate sedation for changes since the prior assessment and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: Medical Center Memorandum 659-112A-5 Standards for Patients Receiving Moderate Sedation for Diagnostic and Therapeutic Procedures was updated to reflect specific requirements for assessment immediately prior to administration of moderate sedation. The Office of Performance and Quality will monitor compliance with documenting the reevaluation of the patient immediately prior to administration.

Recommendation 17. We recommended that providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2017

Facility response: The Chief of Medicine service has instructed all providers that the consent must be updated if changes are made in who is performing the moderate sedation procedure. The Nurse Manager has instructed the nurses when they check the consent each morning in pre-operation to ensure names of all providers who are going to be involved in the procedure that day are listed on the consent. The Office of Performance and Quality will monitor compliance.

Recommendation 18. We recommended that clinical employees discharge outpatients from the recovery area with orders given by a qualified provider or according to criteria approved by moderate sedation clinical leaders and that clinical managers monitor compliance.

Concur

Target date for completion: September 1, 2017

Facility response: Medical Center Memorandum 659-112A-5 Standards for Patients Receiving Moderate Sedation for Diagnostic and Therapeutic Procedures was updated to include revised discharge criteria for moderate sedation. In addition, the Moderate Sedation Discharge template was revised to include the applicable discharge criteria. The Office of Performance and Quality will monitor compliance to ensure orders are given by a qualified provider or the discharge criteria.

Recommendation 19. We recommended that the facility integrate the community nursing home program into its quality improvement program.

Concur

Target date for completion: August 1, 2017

Facility response: The Community Nursing Home Oversight Board has reported to the Clinical Executive Board since January 2017. The Clinical Executive Board then reports the data to the Executive Leadership Board for Quality Safety, and Value.

Recommendation 20. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Concur

Target date for completion: July 1, 2017

Facility response: The non-compliant finding for this recommendation was three cases that occurred in December 2015. Nurses and social workers have recently been compliant in making cyclical clinical visits as required. Audits will be completed by the Office of Performance and Quality to ensure compliance.

Recommendation 21. We recommended that facility managers ensure Disruptive Behavior Committee discussion of patients' disruptive or violent behavior and entry of a progress note into the patients' electronic health records.

Concur

Target date for completion: September 1, 2017

Facility response: The Disruptive Behavior Committee discussion of a patient's disruptive or violent behavior is discussed electronically and/or in person during the committee meeting. The secretary for the committee will ensure that all discussion regarding patient behaviors is included in the monthly committee minutes. A member of the Disruptive Behavior Committee will ensure that the discussion of the patients' disruptive or violent behavior is reflected in a progress note within the patients' electronic medical record. In addition, initiation of the Patient Record Flag is documented in the electronic medical record. The Office of Performance and Quality will audit patient electronic medical records to ensure progress notes (to include initiation of a patient record flag as appropriate) are entered for each patient discussed in the Disruptive Behavior Committee.

Recommendation 22. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.

Concur

Target date for completion: August 1, 2017

Facility response: The notification letter was updated to include the right to request/appeal the Patient Record Flag in Computerized Patient Record System records will be monitored by the Office of Performance and Quality to ensure compliance with the notification requirements.

Recommendation 23. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire, ensure training is documented in employee training records, and monitor compliance.

Concur

Target date for completion: September 1, 2017

Facility response: Managers were informed that they must ensure all required staff complete all relevant levels of Prevention and Management of Disruptive Behavior Training within 90 days of hire. The Chief of Workforce Development will monitor compliance.

Recommendation 24. We recommended that Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document monthly self-inspections and that program managers monitor compliance.

Concur

Target date for completion: August 1, 2017

Facility response: Monthly self-inspections will be completed as required in the Substance Abuse Residential Treatment Program. The self-inspection checklist was revised to include a more robust assessment of the unit. The Substance Abuse Services Coordinator will monitor compliance. Results will be reported to the Clinical Executive Board for oversight.

Recommendation 25. We recommended that Substance Abuse Residential Rehabilitation Treatment Program employees conduct and document every 2-hour rounds of all public spaces, daily bed checks, and daily resident room inspections for unsecured medications and that program managers monitor compliance.

Concur

Target date for completion: August 1, 2017

Facility response: Nursing staff were instructed at the April 2017 staff meetings to conduct and document every two hours on the rounds boards 100 percent of the time. Charge nurses are responsible for ensuring rounds are conducted and documented. The Nurse Manager will audit Substance Abuse Residential Rehabilitation Treatment Program every two hours Environment of Care Rounds Sheet and Patient Count Activity Sheet daily for compliance.

Recommendation 26. We recommended that facility managers ensure the Substance Abuse Residential Rehabilitation Treatment Program unit's non-main entry door is alarmed at all times and that program managers monitor compliance.

Concur

Target date for completion: August 1, 2017

Facility response: An alarm will be added to the non-main entry door to the unit. The Substance Abuse Services Coordinator will check the alarm weekly to monitor compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
Inspection Team	Alice Morales-Rullan, MSN, RN, Team Leader Darlene Conde-Nadeau, MSN, ARNP Charles Cook, MHA Martha Kearns, MSN, FNP Lauren Olstad, MSW, LCSW Michelle Wilt, MBA, BSN Bobby Kirby, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Limin Clegg, PhD Jennifer Reed, RN, MSHI Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BS, BA Carol Torczon, MSN, ACNP Mary Toy, RN, MSN Julie Watrous, RN, MS

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

Endnotes

[a] The references used for QSV were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The references used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[j] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[k] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: December 19, 2016.