Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03078-44

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

December 9, 2009

Washington, DC 20420

## Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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# Executive Summary

## Introduction

During the week of September 21–25, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the W.G. (Bill) Hefner VA Medical Center (the medical center), Salisbury, NC. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 408 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

## Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Improved Care for Patients with Diabetes Mellitus (DM).
- Improved Access to Care.

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to:

- Ensure that all fire extinguishers are readily accessible.
- Require that fire drills are conducted quarterly in the clinical laboratory.
- Ensure that furnishings on the acute mental health (MH) unit meet safety standards.
- Require that MH staff and the Multidisciplinary Safety Inspection Team (MSIT) members complete required annual training and that an effective tracking system is implemented to monitor compliance.
- Ensure that hand hygiene data are monitored and reported and that deficiencies are addressed.
- Ensure that designated employees receive N95 respirator fit testing and that an effective tracking system is implemented to monitor compliance.
- Require that security of the mobile magnetic resonance imaging (MRI) unit is strengthened.
- Ensure that MRI personnel training records contain documentation of annual MRI safety training.

- Ensure that MRI staff competency evaluations are completed in accordance with local policy.
- Require that the MRI patient screening process is completed, as required by local policy.
- Ensure that the Ongoing Professional Practice Evaluation (OPPE) plan, provider profiles, and privileges comply with Veterans Health Administration (VHA) requirements.

The medical center complied with selected standards in the following three activities:

- Coordination of Care.
- Medication Management.
- QM.

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg Office of Healthcare Inspections.

## Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

*(original signed by:)*
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Introduction

## Profile

**Organization.** The medical center is located in Salisbury, NC, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three outpatient clinics in Charlotte, Hickory, and Winston-Salem, NC. The medical center is part of VISN 6 and serves a veteran population of about 229,600 in 23 counties throughout North Carolina.

**Programs.** The medical center has 92 hospital beds and provides inpatient medical and surgical, MH, and advanced rehabilitation care services. The medical center also has 150 community living center (CLC) beds and operates several regional referral and treatment programs, including the Specialized Intensive Post Traumatic Stress Disorder Unit and the Substance Abuse Residential Rehabilitation Treatment Program.

**Affiliations and Research.** The medical center is affiliated with Wake Forest University's School of Medicine and the Edward Via Virginia College of Osteopathic Medicine and provides training for 41 residents and 31 medical students. In addition, the medical center has 71 affiliated training programs in multiple health care fields. In fiscal year (FY) 2008, the medical center had 11 active research projects and a research budget of $295,000. Major areas of research included post-deployment MH of returning Operation Enduring Freedom and Operation Iraqi Freedom Veterans, traumatic brain injury, and rehabilitation of functional impairment associated with low vision and blindness.

**Resources.** In FY 2008, medical care expenditures totaled more than $279.6 million. The FY 2009 medical care budget was over $307.5 million. FY 2008 staffing was 1,785 full-time employee equivalents (FTE), including 138 physician and 474 nursing FTE.

**Workload.** In FY 2008, the medical center treated over 67,000 unique patients. It provided more than 26,700 inpatient days in the hospital and provided approximately 43,700 inpatient days in the CLC units. The inpatient care workload totaled 1,045 discharges, and the average daily census, including CLC patients, was 192. Outpatient workload totaled approximately 441,900 visits.

## Objectives and Scope

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging (C&P).
- QM.

The review covered medical center operations for FY 2008 and FY 2009 through September 21, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina,* Report No. 06-02245-220, September 25, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 408 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective action.

# Organizational Strengths

## Improved Care for Patients With Diabetes Mellitus

The medical center implemented a systems-based approach to improve the delivery of care for patients with DM through standardization of care and goal-oriented outcomes. Patients with elevated HbA1c[1] levels were targeted for improvement, and HEDIS[2] standards were used to measure outcomes. Multiple approaches were utilized, including education, peer review, and peer comparison reports. The impact of these interventions was monitored weekly and monthly. Performance measures show that the overall care of patients with DM has improved. The medical center went from three of seven DM performance measures meeting or exceeding VHA's target goals in FY 2008, to six of seven surpassing the target goals in FY 2009.

## Improved Access to Care

In August 2008, the medical center implemented a VISN Support Services Center (VSSC) "Pending Report Process" to decrease the number of veterans waiting over 30 days for scheduled appointments. The process actively engages all levels of medical center staff, including schedulers, service administrative officers (AOs), associate chiefs of staff (ACOS), and senior management, in a systematic and proactive way of monitoring future scheduled appointments. Service AOs or ACOS report outstanding appointments on a weekly basis to medical center leadership. In FY 2009, there was an increase from 4 (40 percent) of 10 clinics to 8 (80 percent) of 10 clinics meeting targets of fewer than 30 days for new appointments.

[1] HbA1c is a blood test that indicates how well a person's blood sugar has been controlled over the last 2–3 months.
[2] Healthcare Effectiveness Data and Information Set (HEDIS) is a group of measures related to quality of care that is reported by most health plans across the nation. It is owned by the National Committee for Quality Assurance.

The VISN identified this process as a best practice, and a storyboard of the process was presented at the VHA Improvement Forum.

# Results

## Review Activities With Recommendations

### Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association (NFPA), and Joint Commission (JC) standards.

We inspected the acute medical/surgical unit, four primary care clinics, the intensive care unit, the emergency department (ED), the dementia unit, two CLC units, and the acute and chronic MH units. We found that the medical center had an EOC program which included regularly scheduled rounds that identified environmental deficiencies. We determined that the infection control (IC) program monitored exposures and infections appropriately. In addition, the IC program monitored the outpatient influenza immunization rates and had a performance improvement (PI) plan in place to follow up as needed.

During our inspection, we identified the following areas that needed improvement.

Fire and Life Safety. The NFPA requires that fire extinguishers be readily accessible in the event of fire. We found fire extinguishers in locked closets in a primary care building, and only one person on each unit had a key to open the closet on their unit.

In addition, the NFPA requires that the medical center conduct fire drills in clinical laboratories at least quarterly. We reviewed fire drill records for FY 2008 and FY 2009 through September 9, 2009, and found that the laboratory only conducted one fire drill in each FY.

MH Unit Safety. We found that dining room chairs in the acute MH unit were lightweight and did not meet JC standards for acute MH units. The standards require that dining room furnishings be physically heavy or secured to

prevent them from being thrown or used as weapons. Managers provided us with a copy of a work order to replace the chairs in patients' rooms; however, the work order did not include the dining room chairs.

Training. VHA policy[3] requires employees on a locked inpatient MH unit and members of the MSIT to complete annual training on environmental hazards that represent a threat to suicidal patients. We reviewed the training records for 29 MH employees and MSIT members and found that none had completed the training.

IC. VHA[4] requires the implementation of a hospital-wide hand hygiene program. We reviewed the medical center's hand hygiene program data for the past 12 months. We found that the data reflected negative trends on several inpatient units and in several outpatient clinical areas, but the information was not routinely analyzed or reported to the appropriate committees. Furthermore, the deficiencies were not consistently addressed.

In addition, Centers for Disease Control and Prevention guidelines require that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza should wear, at a minimum, a fit-tested disposable N95[5] respirator. We reviewed a total of 23 employee records from Medicine Service (the bronchoscopy area), Radiology Service, the medical unit, and the ED for evidence of fit testing during the past 12 months. We found that 6 (26 percent) of the 23 employees had not received the required annual N95 fit testing.

**Recommendation 1** We recommended that the VISN Director ensure that the Medical Center Director requires that all fire extinguishers are readily accessible, in accordance with NFPA requirements.

The VISN and Medical Center Directors concurred with the finding and recommendation. Locks have been removed from all cabinets containing fire extinguishers except for those on the locked MH units. All staff on the locked MH

[3] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.
[4] VHA Directive 2005-002, *Required Hand Hygiene Practices,* January 13, 2005.
[5] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

units have a key to unlock the cabinets. The corrective actions are acceptable, and we consider this recommendation closed.

**Recommendation 2** We recommended that the VISN Director ensure that the Medical Center Director requires that fire drills are conducted quarterly in the clinical laboratory, as required by the NFPA.

The VISN and Medical Center Directors concurred with the finding and recommendation. The 2010 fire drill schedule has been updated to include the clinical laboratory. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

**Recommendation 3** We recommended that the VISN Director ensure that the Medical Center Director requires that the furnishings on the acute MH unit meet safety standards.

The VISN and Medical Center Directors concurred with the finding and recommendation. Replacement furnishings that meet JC standards have been approved. An interim safety plan is in effect until the new furniture is in place. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

**Recommendation 4** We recommended that the VISN Director ensure that the Medical Center Director requires that MH staff and MSIT members complete the required annual training on environmental hazards that represent a threat to suicidal patients and that an effective tracking system is implemented to monitor compliance.

The VISN and Medical Center Directors concurred with the finding and recommendation. MH staff and MSIT members have completed the required annual training on environmental hazards. A system is now in place to monitor initial and annual training compliance. The corrective actions are acceptable, and we consider this recommendation closed.

**Recommendation 5** We recommended that the VISN Director ensure that the Medical Center Director requires that hand hygiene data are monitored and reported and that deficiencies are addressed.

The VISN and Medical Center Directors concurred with the findings and recommendation. A hospital-wide hand hygiene program has been implemented. Compliance data will be

reported regularly to the appropriate committees, and action plans will be generated to address deficiencies. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

**Recommendation 6** We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees receive N95 respirator fit testing and that an effective tracking system is implemented to monitor compliance.

The VISN and Medical Center Directors concurred with the finding and recommendation. A tracking system to monitor compliance has been developed, and currently, 100 percent of designated clinical staff have received N95 respirator fit testing. Safety staff will review compliance data regularly to enhance accountability. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI areas. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the permanent and mobile MRI areas, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the medical center could strengthen some aspects of its MRI program.

The medical center had conducted a risk assessment of the environment, as required by The JC. However, we found that the medical center was not in compliance in several areas even though compliance was indicated on the risk assessment. In addition, corrective actions were not tracked to completion. We identified the following areas that needed improvement.

Environmental Safety. The medical center had appropriate signage and barriers to prevent unauthorized or accidental access to the permanent MRI area. However, security of the entrances to Zones III and IV[6] in the mobile unit should be improved. The main door to the mobile unit remains unlocked when the MRI technician is in the unit. Also, when

[6] Zones III and IV are areas restricted to only essential MRI personnel and previously screened patients.

the technician is inside Zone IV with the patient, the door between Zones III and IV has to remain open due to the size of the space. Under these conditions, unauthorized or accidental access to Zone IV could occur.

MRI Safety Training. Personnel who have access to the MRI area must receive annual MRI safety training. We reviewed the training records of six MRI personnel. Four had been in their MRI position for more than 2 years but had no documentation of training in 2008. All six received MRI safety training several weeks prior to our site visit to complete their 2009 training requirement.

Competency Evaluations. MRI personnel had current competencies documented; however, neither the method of evaluating the competencies nor the level of competence achieved was documented, as required by local policy.

Screening. Local policy requires that all patients must undergo safety screening prior to an MRI procedure. The process includes the use of a detailed checklist which requires documentation that the items have been reviewed with the patient at two separate times, including once just prior to entering the MRI suite. We reviewed the medical records of 10 patients who received an MRI. In all cases, we found a template screening form in each patient's electronic medical record that was completed by the ordering physician at the time of the MRI request. However, there was no evidence that the patient was present when this form was completed. Although MRI technicians told us that they used this form and asked the patients the same questions when they arrived for their MRI, there was no documentation of this. In addition, the template form did not contain all required questions and did not include the patient's signature.

The template form allowed the ordering physician to indicate if the patient had any potential contraindications which might preclude the use of a contrast agent. Five (50 percent) of the 10 patients whose records we reviewed received a contrast agent. Although contraindications were indicated for three of these patients, we found no documentation to support the determination that the patients were not at risk.

**Recommendation 7** We recommended that the VISN Director ensure that the Medical Center Director requires that security of the mobile MRI unit is strengthened.

The VISN and Medical Center Directors concurred with the findings and recommendation. A deadbolt lock is now in place to prevent unauthorized or accidental access to Zone IV in the mobile MRI Unit. The corrective actions are acceptable, and we consider this recommendation closed.

**Recommendation 8** We recommended that the VISN Director ensure that the Medical Center Director requires that MRI personnel training records contain documentation of annual MRI safety training.

The VISN and Medical Center Directors concurred with the finding and recommendation. Annual safety training is now mandatory and is tracked through a VA computer program. The corrective actions are acceptable, and we consider this recommendation closed.

**Recommendation 9** We recommended that the VISN Director ensure that the Medical Center Director requires that MRI staff competency evaluations are completed in accordance with local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. As of October 1, 2009, all MRI staff competencies were completed in accordance with local policy. The corrective actions are acceptable, and we consider this recommendation closed.

**Recommendation 10** We recommended that the VISN Director ensure that the Medical Center Director requires that the MRI patient screening process is completed, as required by local policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Computerized Patient Record System MRI screening template has been modified to reflect the requirements of local policy, and processes have been implemented to improve screening documentation. The corrective actions are acceptable, and we consider this recommendation closed.

## Physician Credentialing and Privileging

The purpose of this review was to determine whether the medical center has consistent processes for C&P physicians. We reviewed selected VHA required elements[7] in physician C&P files and provider profiles. We also reviewed meeting minutes that included discussions relevant to our review.

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

We reviewed 10 physicians' C&P files and profiles. We found that all 10 had current licenses and that primary source verification had been obtained for education, training, and certifications. Focused Professional Practice Evaluations were appropriately implemented for one physician requesting additional privileges and for two physicians hired within the past 12 months. Medical Staff Executive Committee and Professional Standards Board meeting minutes included detailed discussions regarding provider privileges. However, we identified the following area that needed improvement.

OPPE. VHA regulations require thorough written plans with specific competency criteria for OPPE for all privileged physicians. We noted that seven of eight OPPE profiles reviewed lacked service-specific and provider-specific competency criteria and data to support current provider privileges.

**Recommendation 11** We recommended that the VISN Director ensure that the Medical Center Director requires that the OPPE plan, provider profiles, and privileges comply with VHA requirements.

The VISN and Medical Center Directors concurred with the finding and recommendation. Service chiefs have been instructed to review and revise OPPE forms. All OPPEs will then be reviewed by the Professional Standards Board to ensure that the plans support the privileges requested and granted. In addition, changes will be made to standardize and consolidate data used in the evaluation process. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

## Review Activities Without Recommendations

### Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed medical records for 17 intra-facility transfers and found that all of the records contained appropriate documentation. We found transfer notes from sending to

receiving units. Also, nursing assessments were documented by the receiving units in a timely manner.

We reviewed the medical records of 22 discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions.

Additionally, we reviewed the medical records of five patients recently discharged from the acute MH unit. We found documentation that patients received information about accessing emergency MH care and were given MH clinic appointments within 2 weeks of discharge. We also found documentation that MH providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. We made no recommendations.

## Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes on the acute medical/surgical unit, the acute MH unit, and the CLC units.

We found that the medical center had a designated Bar Code Medication Administration Program coordinator who had appropriately identified and addressed problems. In general, nursing staff documented PRN (as needed) pain medication effectiveness within the timeframe specified by local policy, and pharmacy staff completed monthly medication reviews for CLC patients. We made no recommendations.

## Quality Management

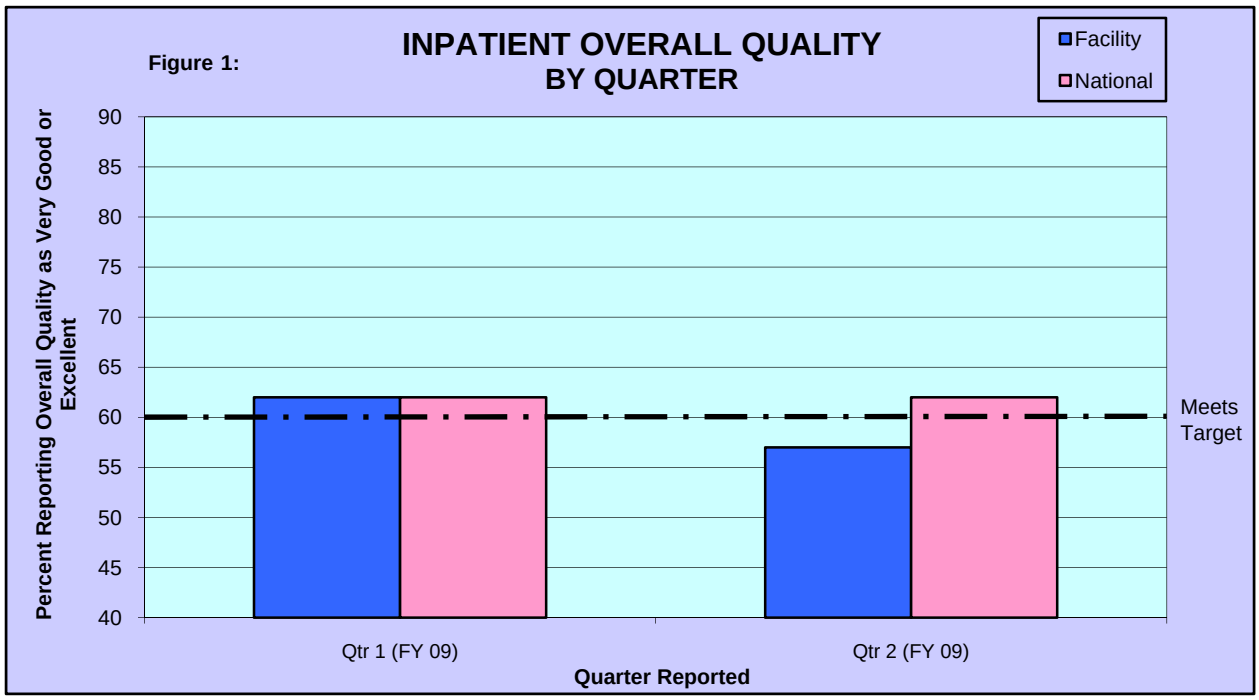
The purposes of this review were to determine whether (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. We reviewed 14 QM and patient safety processes, and we evaluated policies, PI data, and other relevant documents. We interviewed appropriate senior managers, patient safety employees, and the QM Coordinator.

The medical center's QM program was effective and well managed, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Meaningful

data were analyzed, trended, and utilized to improve patient care and patient safety. We made no recommendations.

## VHA Satisfaction Surveys

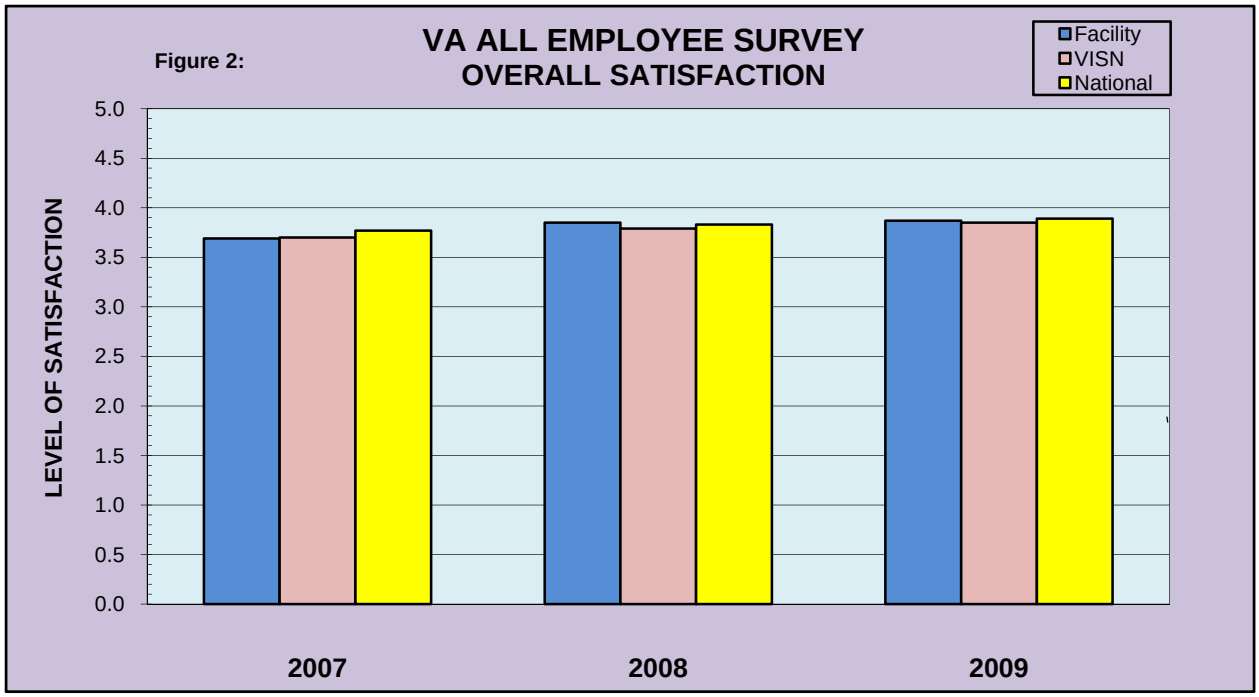
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1 and 2 of FY 2009.[8] The target score is noted on the graph.




Employees are surveyed annually. Figure 2 on the next page shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

[8] Due to technical difficulties with VHA's outpatient survey data, no outpatient satisfaction scores are available for quarters 1 and 2 of FY 2009.

**Figure 2:**


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** November 18, 2009

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

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

**To:** Associate Director, St. Petersburg Healthcare Inspections Division (54SP)

Director, Management Review Service (10B5)

I concur with all recommendations for improvement indentified in the report and approve the responses and action plans for each recommendation provided by the Director, Salisbury VA Medical Center.

(*original signed by:)*
Daniel H. Hoffman, FACHE
Network Director, VISN 6

# Medical Center Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** November 18, 2009

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

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

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

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Combined Assessment Program Review draft report. I concur with all recommendations for improvement identified in the report.

2. The responses and action plans for each recommendation are enclosed.

3. Should you have any questions regarding the comments or implementation plans, please contact me at (704) 638-9000 ext. 3344.

(*original signed by:)*
Carolyn Adams, Director
W.G. (Bill) Hefner VA Medical Center

## Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

**OIG Recommendations**

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director requires that all fire extinguishers are readily accessible, in accordance with NFPA requirements.

**Concur**

**Facility Response:** All Fire Extinguisher Equipment Cabinet locks have been removed except on the locked Mental Health units. All staff on the Mental Health units carry a key that unlocks the cabinet.
**Target Completion Date:** Completed.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires that fire drills are conducted quarterly in the clinical laboratory, as required by the NFPA.

**Concur**

**Facility Response:** The 2010 Fire Drill Matrix has been updated to reflect this requirement. A fire drill was performed in the Laboratory on October 23, 2009. Fire drills are monitored through the Environment of Care Committee.
**Target Completion Date:** Completed.

**Recommendation 3.** We recommended that the VISN Director ensure that the Medical Center Director requires that the furnishings on the acute MH unit meet safety standards.

**Concur**

**Facility Response:** The Multidisciplinary Safety Inspection Team (MSIT) has identified a replacement for the dining room chairs, and the selection has been approved by leadership. The chairs have been ordered by Facility Management Service (FMS). The Interim Safety Plan to abate this risk is that patients are continuously monitored by staff while in the dining room. The dining room remains locked at all times other than meal times. This Mental Health Interim Safety Plan will remain in effect until the new chairs are in place.
**Target Completion Date:** January 8, 2010.

**Recommendation 4.** We recommended that the VISN Director ensure that the Medical Center Director requires that MH staff and MSIT members complete the required annual training on environmental hazards that represent a threat to suicidal patients and that an effective tracking system is implemented to monitor compliance.

**Concur**

**Facility Response:** The training module "Mental Health EOC Checklist Training" was created in My Peak on September 24, 2009. This is now a mandatory training for all Mental Health staff on the locked unit and the MSIT. The training is required annually. Compliance is tracked through the electronic TEMPO system (automatic documentation of My Peak training). The entire MSIT team and 100 percent of the required mental health staff have also completed the training. The Associate Chief of Staff for Mental Health and Behavioral Sciences has been assigned the responsibility for monitoring the annual training.
**Target Completion Date:** Completed.

**Recommendation 5.** We recommended that the VISN Director ensure that the Medical Center Director requires that hand hygiene data are monitored and reported and that deficiencies are addressed.

**Concur**

**Facility Response:** The Salisbury VAMC has implemented and enforced a hospital-wide hand-washing program in line with the CDC Universal Precaution recommendations and accepted principles of hand hygiene practice as indicated in the Salisbury VAMC IC Manual. Tracking and trending of hand hygiene compliance and aggregate data is reported monthly to the IC Committee, and quarterly to the Clinical Executive Board and the Executive Committee of the Governing Body. Action plans are generated for underperforming areas with appropriate reporting to respective committees. To address negative trends in hand hygiene, the accountability of staff has been enhanced by instituting progressive disciplinary action for recurrent violators while concurrently providing positive reinforcement to adherent staff. There is also a future plan for incentives to be given to staff that are compliant. Furthermore, to enhance compliance with hand hygiene, alcohol based hand sanitizers have been placed at all entrances to patient rooms, elevators and entrances. An increased number of carts with gowns, gloves, masks and alcohol based hand sanitizers have also been added on inpatient units.
**Target Completion Date:** Completed.

**Recommendation 6.** We recommended that the VISN Director ensure that the Medical Center Director requires that designated employees

receive N95 respirator fit testing and that an effective tracking system is implemented to monitor compliance.

**Concur**

**Facility Response:** A list of required personnel has been identified, and currently, 100 percent have received N95 respirator fit testing. A process was immediately implemented to ensure all designated clinical staff who present at New Employee Orientation (NEO) will be fit tested by the third day of NEO by the Industrial Hygienist. Human Resources provides a listing of the incoming new employees to Safety staff the week prior to NEO training. The listing identifies the employees with their assigned service and job title, allowing the Industrial Hygienist to identify who needs to be enlisted in the program and receive the testing and training. A tracking system to monitor compliance has been developed. A report will be submitted monthly to the EOC Committee by the Industrial Hygienist and also quarterly to the Executive Committee of the Governing Body.
**Target Completion Date:** Completed.

**Recommendation 7.** We recommended that the VISN Director ensure that the Medical Center Director requires that security of the mobile MRI unit is strengthened.

**Concur**

**Facility Response:** A deadbolt lock is now being used when the technician is inside Zone IV with a patient to avoid unauthorized or accidental access to Zone IV. All staff are aware of this change.
**Target Completion Date:** Completed.

**Recommendation 8.** We recommended that the VISN Director ensure that the Medical Center Director requires that MRI personnel training records contain documentation of annual MRI safety training.

**Concur**

**Facility Response:** The MRI personnel annual safety training is now mandatory and has been placed on MY PEAK. Evidence of training can be tracked through TEMPO and noted on the updated competency checklists.
**Target Completion Date:** Completed.

**Recommendation 9.** We recommended that the VISN Director ensure that the Medical Center Director requires that MRI staff competency evaluations are completed in accordance with local policy.

**Concur**

**Facility Response:** As of October 1, 2009, all competencies have been completed utilizing the station format, which includes the method of evaluation and the level of competence.
**Target Completion Date:** Completed.

**Recommendation 10.** We recommended that the VISN Director ensure that the Medical Center Director requires that the MRI patient screening process is completed, as required by local policy.

**Concur**

**Facility Response:** The CPRS MRI screening template was modified to include the following statement: "Information above has been reviewed with the patient. The patient agrees to have MRI exam." This statement guarantees that the clinician interacted with the patient to obtain current screening information.

A new secondary screening questionnaire has been implemented. Additional questions required were included in the new questionnaire. Following completion by the patient, the technologist reviews the questionnaire with the patient to assure completion and understanding. At the end of this process, both the patient and the technologist sign the completed questionnaire and this document is scanned into the medical record.

All patients are screened for potential contraindications to contrast agents. Those patients identified with potential contraindications who subsequently received contrast agents did not have documentation to support the use of the contrast agents. To correct this, a CPRS note is entered by the Imaging staff, acknowledging the review of the diagnosis, potential contraindications, and the Estimated Glomerular Filtration Rate, and the appropriateness of the use of contrast agents.
**Target Completion Date:** Completed.

**Recommendation 11**. We recommended that the VISN Director ensure that the Medical Center Director requires that the OPPE plan, provider profiles, and privileges comply with VHA requirements.

**Concur**

**Facility Response:** Immediately following the review, the C&P coordinator contacted the VA Hudson Valley Healthcare System, identified by the CAP reviewer as a "best practice," to send samples of their OPPE forms. Upon receipt, these forms were forwarded to the service chiefs for their review and modification as appropriate to the service and providers' specialty. The service chiefs were instructed to revise all OPPEs and send them to the Chief of Staff by Nov 30, 2009, for his review. The Professional Standards Board is scheduled to meet on

December 10, 2009, to review all the OPPEs to ensure that the plan supports the privileges requested and granted. Furthermore, raw data for the service provider profile forms will be consolidated into one form to guarantee that all parameters in the OPPE are supported by relevant and measurable data.

**Target Completion Date:** December 10, 2009.

# OIG Contact and Staff Acknowledgments

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|---|---|
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