Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02074-06

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

October 27, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	Huntington VA Medical Center
FY	fiscal year
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
QM	quality management
SDS	same day surgery
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 4, 2014.

Review Results: The review covered six activities. We made no recommendations in the following activity:

- Coordination of Care

The facility's reported accomplishment was offering proactive patient-centered services, including alternative therapies such as acupuncture, pet therapy, recreational therapy, and music therapy.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure the Quality, Safety, and Value Council meets monthly. Consistently report results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners to the Medical Staff Council. Ensure the Medical Staff Council discusses and documents approval of use of another facility's providers for teledermatology services. Require the Cardiopulmonary Resuscitation Committee to collect code data. Ensure the Transfusion Review Committee members from Medicine and Anesthesia Services consistently attend meetings.

Environment of Care: Ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes. Require that all food service employees use hairnets and gloves when serving food. Ensure all privacy curtains in same day surgery and on the post-anesthesia care unit have open mesh tops that extend 18 inches for sprinkler coverage. Require that same day surgery has designated rooms for the storage of dirty instruments, equipment, and housekeeping supplies and that these rooms and the soiled utility room on the post-anesthesia care unit are secured. Ensure designated eye clinic employees receive eye laser safety training annually.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Acute Ischemic Stroke Care: Develop an acute ischemic stroke policy that addresses all required items. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in the emergency department, on the intensive care unit, and on the acute inpatient units. Provide printed stroke education to patients upon discharge. Collect stroke data, and report it to the Veterans Health Administration.

Magnetic Resonance Imaging Safety: Ensure that all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 19–27, for the full text of the Directors' comments.) We consider recommendations 2, 7, 8, 9, and 14 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

The scope of the CAP review is limited. A serious issue regarding QM that came to our attention and was outside the scope of this review will be referred for a hotline investigation.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- MRI Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013 and FY 2014 through August 8, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment*

Program Review of the Huntington VA Medical Center, Huntington, West Virginia, Report No. 12-02602-79, January 7, 2013). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 71 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 171 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Proactive Patient-Centered Innovative Services

Several innovative services are offered to achieve proactive, personalized, and patient-centered care. These include alternative therapies such as acupuncture; pet therapy; recreational therapy, including the Healing Waters Fly Fishing program; and music therapy, including the Guitars for Vets program. Additionally, visiting hours are less restrictive than previously, and an Intensive Care Unit Care Line was developed so that families can have better access to information about their loved ones.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	• Although facility policy required monthly meetings, the Quality, Safety, and Value Council did not meet January through June 2014.
	The protected peer review process met selected requirements: • The Peer Review Committee was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the Peer Review Committee. • The Peer Review Committee submitted quarterly summary reports to the Medical Executive Committee. • Unusual findings or patterns were discussed at the Medical Executive Committee.	
X	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the Medical Executive Committee.	Nine profiles reviewed: • Results of three Focused Professional Practice Evaluations completed in FY 2013 were not reported to the Medical Staff Council. This was a repeat finding from the previous CAP review.

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • There was no evidence that data were collected.
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Transfusion Review Committee meeting minutes reviewed: • Clinical representatives from Medicine and Anesthesia Services attended only two of four meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Quality, Safety, and Value Council meet monthly.

2. We recommended that processes be strengthened to ensure that results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently reported to the Medical Staff Council.

3. We recommended that the Medical Staff Council discuss and document its approval of the use of another facility's providers for teledermatology services.

4. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee collects code data.

5. We recommended that processes be strengthened to ensure that the Transfusion Review Committee members from Medicine and Anesthesia Services consistently attend meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the SDS, intensive care, telemetry, inpatient medical/surgical, and dialysis units. We also inspected an oncology clinic, the ED, the PACU, the eye clinic, and the women's health building. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 13 employee training records (7 SDS, 5 PACU, and 1 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
X	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Eight months of Infection Prevention/Control Committee meeting minutes reviewed: • Minutes did not reflect infection surveillance activities associated with specific construction projects and/or interventions.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA policy on food service management reviewed: • We observed food service employees serving food in the cafeteria without using hairnets and gloves, the required safety and health barriers.
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
X	Environmental safety requirements in SDS and on the PACU were met.	• The two SDS negative pressure room anterooms were being used for storage of dirty instruments, equipment, and housekeeping supplies, and both rooms were unlocked and unattended. • The PACU soiled utility room was unlocked and unattended. • In SDS and on the PACU, not all privacy curtains had open mesh tops that extended 18 inches for sprinkler coverage.
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
X	Designated eye clinic employees received laser safety training with the frequency required by local policy.	• The provider who performed eye laser procedures did not receive annual laser safety training.
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

6. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

7. We recommended that processes be strengthened to ensure that all food service employees use hairnets and gloves when serving food.

8. We recommended that all privacy curtains in same day surgery and on the post-anesthesia care unit have open mesh tops that extend 18 inches for sprinkler coverage.

9. We recommended that same day surgery have designated rooms for the storage of dirty instruments, equipment, and housekeeping supplies and that these rooms and the soiled utility room on the post-anesthesia care unit be secured.

10. We recommended that processes be strengthened to ensure that designated eye clinic employees receive eye laser safety training annually and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• None of the EHRs of the 14 patients with identified learning barriers reflected medication counseling accommodation to address the barriers.
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

11. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance is monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 35 randomly selected patients who experienced stroke symptoms, and 20 staff training records (5 ED, 5 intensive care unit, 5 4South, and 5 5South), and we conversed with key employees. We also conducted onsite inspections of the ED, the intensive care unit, and two acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility did not have a policy in place that addressed the management of AIS.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the 35 EHRs contained documented evidence of completed stroke scales.
	Clinicians provided medication tissue plasminogen activator timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the two acute inpatient units, in the ED, or on the intensive care unit.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 35 EHRs contained documentation that stroke education was provided to the patient/caregiver.
	The facility provided training to staff who are involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and/or reported to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

12. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

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

14. We recommended that stroke guidelines be posted in the emergency department, on the intensive care unit, and on the acute inpatient units.

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

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

MRI Safety

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

We reviewed relevant documents and the training records of 39 employees (30 randomly selected Level 1 ancillary staff and 9 designated Level 2 MRI personnel), and we conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• None of the Level 2 MRI personnel received level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

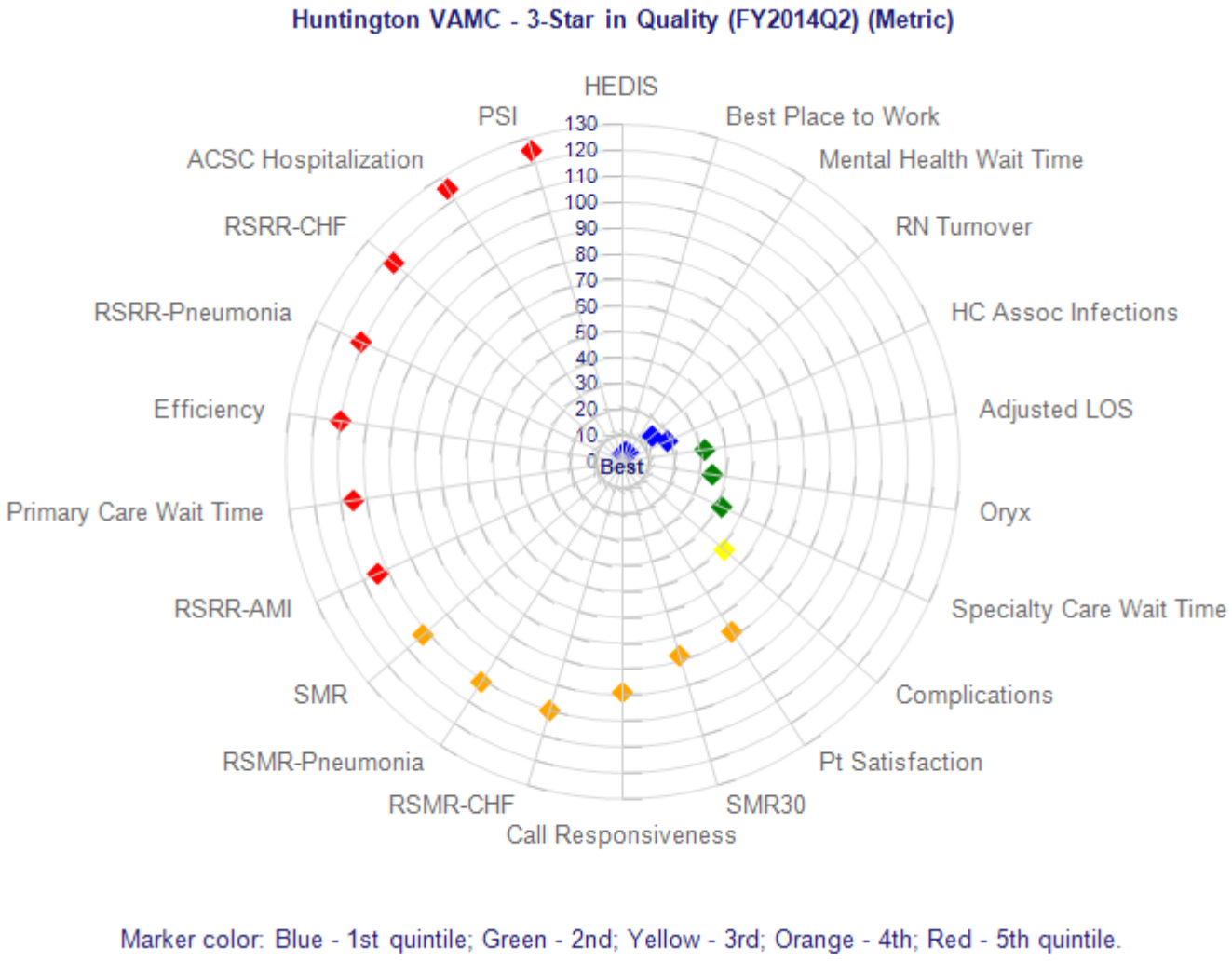
Recommendation

17. We recommended that processed be strengthened to ensure that all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Facility Profile (Huntington/581) FY 2014 through July 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$214.9
Number of:	
• **Unique Patients**	27,408
• **Outpatient Visits**	293,044
• **Unique Employees**[2]	990
Type and Number of Operating Beds:	
• **Hospital**	80
• **Community Living Center**	NA
• **Mental Health**	NA
Average Daily Census (as of June 2014):	
• **Hospital**	40
• **Community Living Center**	NA
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Prestonsburg/581GA Charleston/581GB Williamson/581GD Logan County/581GE
VISN Number	9

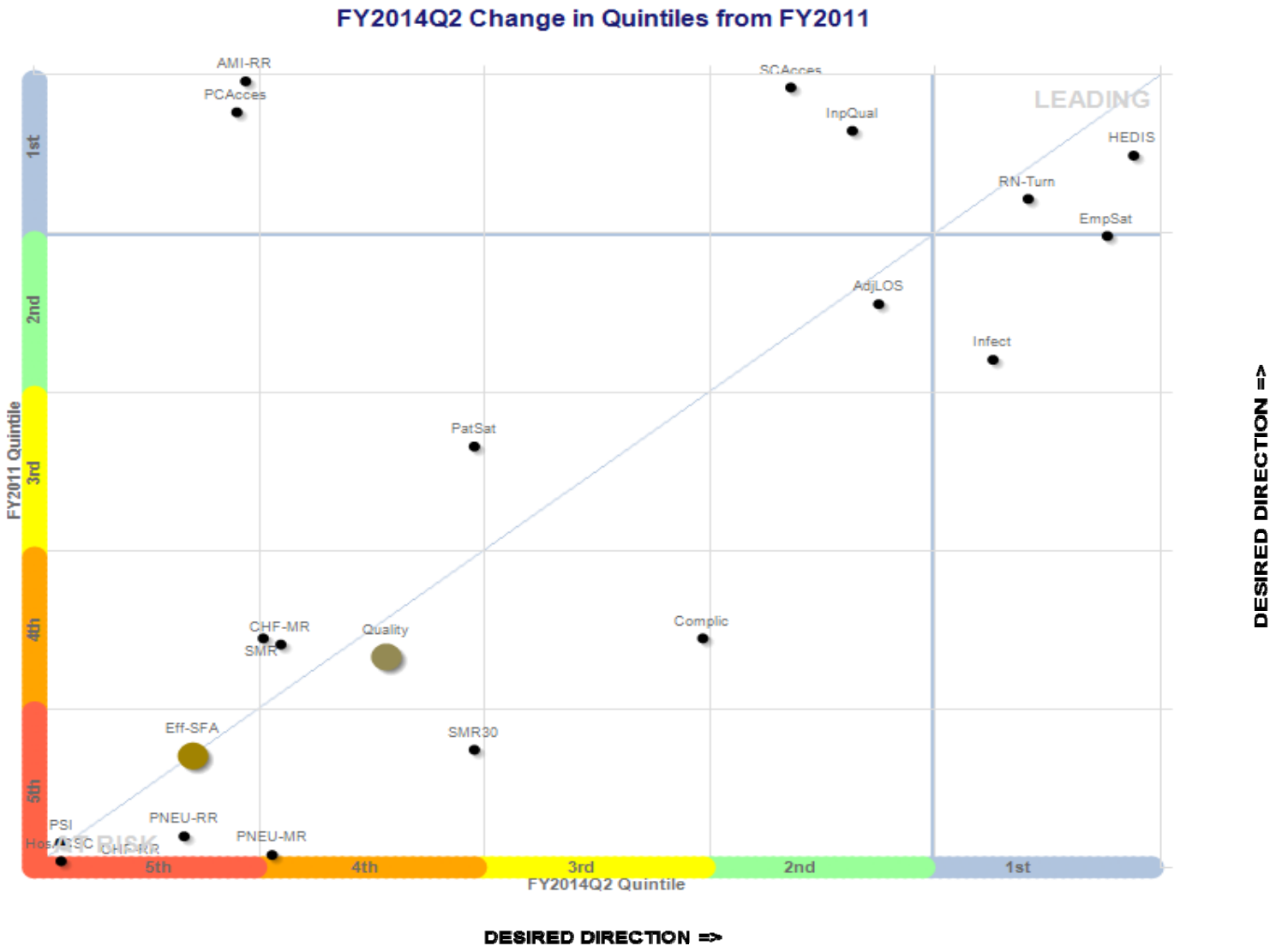
[1] All data is for FY 2014 through July 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 6, 2014

From: Director, VA Mid South Healthcare Network (10N9)

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

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. I have reviewed and concur with the findings and recommendations in the report of the CAP review of the Huntington VA Medical Center, Huntington, WV.

2. Corrective action plans have been established with completion dates as detailed in the attached report.

3. If you have any questions or need additional information, contact Cynthia L. Johnson, VISN 9 Quality Management Officer or Joseph Schoeck, VISN 9 Health Systems Specialist/Staff Assistant to the Network Director at 615-695-2200.

(original signed by:)
JOHN E. PATRICK
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 30, 2014

From: Director, Huntington VA Medical Center (581/00)

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

To: Director, VA Mid South Healthcare Network (10N9)

I wish to extend my thanks to the Office of the Inspector General (OIG) for conducting a professional review of the organization. The recommendations contained in the Comprehensive Assessment Program report have been reviewed. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(original signed by:)
J. Brian Nimmo
Medical Center 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 the Quality, Safety, and Value Council meet monthly.

Concur

Target date for completion: March 31, 2015

Facility Response: The facility Quality/Safety/Value Council will begin meeting monthly. The next scheduled meeting, with the Medical Center Director as chairperson, is on October 8, 2014. Evidence of compliance with the recommendation will be documented by monthly meeting minutes, October 2014 through March 31, 2015.

Recommendation 2. We recommended that processes be strengthened to ensure that results of Focused Professional Practice Evaluations for newly hired licensed independent practitioners are consistently reported to the Medical Staff Council.

Concur

Target date for completion: Completed

Facility Response: In January 2014 the organization implemented a standardized Focused Professional Practice Evaluation (FPPE) spreadsheet for tracking/monitoring timely completion of FPPE in all clinical services. Each Service updates the tracker on a monthly basis. The information is then reviewed monthly by staff in the Credentialing office and the Chief of Staff's office. Service Chiefs also report on the status of all active FPPEs during the monthly Professional Standards Board (PSB), with discussions and decisions focused on how to ensure timely completion of FPPEs for individuals with low volume. This information is reported up to the Medical Staff Council.

Recommendation 3. We recommended that the Medical Staff Council discuss and document its approval of the use of another facility's providers for teledermatology services.

Concur

Target date for completion: March 31, 2015

Facility Response: The Medical Staff Council (MSC) discussed and documented approval of tele-dermatology services on July 7, 2014. The Facility Telehealth Coordinator is invited to all MSC meetings to ensure the use of all new tele-health

technology is presented to MSC for approval prior to implementation. Compliance will be evidenced by documentation of MSC minutes for six (6) consecutive months (October 2014 through March 2015).

Recommendation 4. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee collects code data.

Concur

Target date for completion: March 31, 2015

Facility Response: Members of the OIG CAP inspection team noted that the Cardiopulmonary Resuscitation Committee reviewed individual episodes of care where resuscitation was attempted.

The Cardiopulmonary Resuscitation Committee will take the monthly reviews collected and it will aggregate them into a monthly report that tracks and trends the following information:

- Errors or deficiencies in technique or procedures
- Lack of availability or malfunction of equipment
- ACLS Algorithms followed appropriately
- Identified Clinical Issues resulting in a Code Blue
- Delays in initiating CPR (<5 minute standard)
- Intubation and use of ETCO2 (if appropriate)
- Number of Codes/Survivals to Discharge (Percentages)
- Code Blue by shift
- Code Blues by Locations
- Rapid Responses/Code Blues (Total Numbers)
- Rapid Response/Code Blues resulted in transfer to Critical Care Unit, telemetry, or remained on the floor
- Rapid Responses by shift
- Rapid Response Locations

The first report will be completed by October 31, 2014 and will aggregate the 4th quarter FY2014 data. The aggregate report will then be reported to the Critical Care Committee and the Medical Staff Council quarterly. Evidence of compliance will be documented in the meeting minutes of the Critical Care Committee and the Medical Staff Council and will represent the 4th quarter FY14 data and the 1st quarter FY15 data.

Recommendation 5. We recommended that processes be strengthened to ensure that the Transfusion Review Committee members from Medicine and Anesthesia Services consistently attend meetings.

Concur

Target date for completion: March 31, 2015

Facility Response: The following corrective action plan was implemented on August 19, 2014.

1. Meetings will be scheduled in advance to provide adequate notice to members to allow for planning to attend the scheduled meeting. The next scheduled meeting is October 27, 2014 at 9 a.m.
2. The Quality Management Coordinator, or designee, will contact all members within 48 hours prior to the scheduled meeting to ensure awareness of the scheduled meeting and any reports that are due.
3. Time has been blocked for the Chief, Anesthesia Services to attend the scheduled meetings.
4. If a member is not able to attend, the Service Chief will be contacted by the QM Coordinator, or designee, to ensure the service is represented for the meeting.

Evidence of compliance will include meeting minutes from the 1st and 2nd quarters FY2015.

Recommendation 6. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in Infection Control Committee minutes.

Concur

Target date for completion: March 31, 2015

Facility response: The Infection Control Practitioner will ensure that infection surveillance activities related to construction projects are completed and that these activities are documented in the meeting minutes of the Infection Control Committee. Evidence of compliance will include meeting minutes, at a minimum of once a quarter, for the 1st and 2nd quarters of FY2015.

Recommendation 7. We recommended that processes be strengthened to ensure that all food service employees use hairnets and gloves when serving food.

Concur

Target date for completion: Completed

Facility Response: Canteen employees were provided with on the spot training during the actual on site survey and were immediately instructed to begin wearing hair nets and gloves. Employees were observed as compliant following this immediate corrective action. On August 23, 2014 the Veterans Canteen Service Central Office (VCSCO) sent a corporate trainer for VCSCO to conduct a Conduct Food Service Sanitation and Safety course for the entire Canteen staff at VAMC Huntington. A total of nine employees, representing 100% of the service's employees) completed the training. The education included training on the importance of hair nets and gloves during food preparation and service. The expectation was set that employees would be held accountable for failure to adhere to these standards. The Service Chief will monitor on a daily basis for continued compliance with these standards.

Recommendation 8. We recommended that all privacy curtains in same day surgery and on the post-anesthesia care unit have open mesh tops that extend 18 inches for sprinkler coverage.

Concur

Target date for completion: Completed

Facility Response: All of the privacy curtains in the Same Day Surgery (SDS) and Post Anesthesia Care Units (PACU) were changed by September 29, 2014. The facility is now 100% compliant in both SDS and the PACU.

Recommendation 9. We recommended that same day surgery have designated rooms for the storage of dirty instruments, equipment, and housekeeping supplies and that these rooms and the soiled utility room on the post-anesthesia care unit be secured.

Target date for completion: Completed

Facility Response: The Same Day Surgery (SDS) unit now has a designated storage room for dirty instruments and equipment. The room is marked with biohazard storage signs and is a locked area. The Post Anesthesia Care Unit (PACU) now has a room that is also designated for soiled items. All rooms designated for receipt of soiled (i.e. dirty) items are now secured by push button locks. Staff are able to access these rooms by entering the correct code to release the lock.

Recommendation 10. We recommended that processes be strengthened to ensure that designated eye clinic employees receive eye laser safety training annually and that compliance be monitored.

Concur

Target date for completion: October 31, 2014

Facility Response: An eye clinic laser safety standard operating procedure (SOP) has been created. Training of the designated eye clinic employees on eye laser safety will be completed through a course in the VA Talent Management System (TMS). Evidence of training will be submitted via a TMS report.

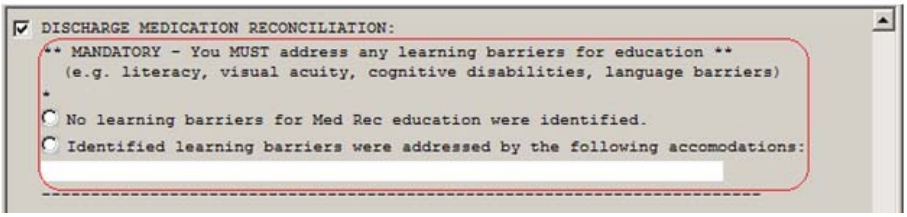
Recommendation 11. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility Response: Documentation is being added to the template used for recording medication reconciliation in the electronic medical record of patients. The template will include mandatory fields that address learning barriers and how these barriers were addressed. Monitoring of compliance with the revised templates will be conducted through clinical pertinence reviews conducted by the clinical services. Clinical pertinence reviews will be reported to the Medical Records Committee as per the routine schedule of the committee. Quality Management will aggregate a report quarterly that records the overall facility compliance rate, which is expected to be 90% or greater each quarter. Evidence of compliance with this recommendation will occur when the target has been reached for three consecutive months.

The following is from the revised template.



Recommendation 12. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility Response: The facility has a draft Medical Center Memorandum (MCM) that was discussed at the Medical Staff Council meeting on September 24, 2014. Additional edits will be made to the draft MCM prior to sending it back to the Medical Staff Council (MSC) for approval. Once approved by the MSC, the MCM will be sent on to the Medical Center Director for final signature approval. Compliance with the contents of the MCM will be monitored by the staff of Quality Management on an ongoing basis (please see the facility response under recommendation 13).

Recommendation 13. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility Response: The facility has established a data collection process with the assistance of the Decision Support System (DSS) Clinical Coordinator. The Assistant Chief, Quality Management will obtain the names of patients who have been in the Emergency Department or on the inpatient units with a stroke diagnosis. Data collection, including review of the patients' medical records, will be conducted monthly.

Aggregate data reports will be provided to the Critical Care Committee for analysis and recommendation. Data will also be reported up to the Medical Staff Council. The first quarter of data reviewed represents the 3rd quarter FY2014. As identified in the data, use of and documentation of the NIH Stroke Scale is below the target for compliance. This will be the first area of improvement that the Critical Care Committee is asked to address.

Recommendation 14. We recommended that stroke guidelines be posted in the emergency department, on the intensive care unit, and on the acute inpatient units.

Concur

Target date for completion: Completed

Facility Response: On Wednesday, August 6, 2014, during the CAP review, FAST (Face-Arms-Speech-Time) signs were laminated and placed in all eleven elevators within the main medical center building, in hallways, all inpatient units and the Emergency Department (ED). All signs are in areas visible to patients, visitors, and employees. Additional posters were laminated and hung within the facility outpatient clinics, the mental health buildings, the women's clinic, and the Community Based Outpatient Clinics (CBOC) and rural outreach clinics on August 7, 2014.

Recommendation 15. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: March 31, 2015

Facility Response: The Emergency Department and inpatient unit (i.e. Intensive Care Unit, 4 South, and 5 South) Nurse Managers, Clinical Unit Coordinators and Clinical Nurse Leaders were educated about the Krames on Demand patient education documentation and how to print the education for patients. Information was also provided on the UP to date system of patient education tools. This was completed by August 6, 2014. Monitoring of compliance will be added to the data collection described in Recommendations #13 and #16 beginning with the 4th quarter FY2014.

Recommendation 16. We recommended that the facility collect and report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: March 31, 2015

Facility Response: As described under Recommendation #13, the facility has established a data collection process. The facility is designated as a "supporting stroke facility" and tissue plasminogen activator will not be given at the Medical Center. The Assistant Chief, Quality Management will collect the names of patients who have been in the Emergency Department or on the inpatient units with a stroke diagnosis. Data collection, including review of the patients' medical records, will be conducted monthly. Aggregate data reports will be provided to the Critical Care Committee for analysis and recommendation. Data will also be reported up to the Medical Staff Council. The first quarter of data reviewed represents the 3rd quarter FY2014.

Recommendation 17. We recommended that processed be strengthened to ensure that all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: November 15, 2014

Facility Response: Imaging service was able to obtain a DVD which reviews all content suggested by the OIG for Level 2 employees. A conference room in the Library has been designated as the training location for employees who need to complete the Level 2 training. Training will include a DVD and review of Medical Center Memorandum PCI-79: Magnetic Resonance Imaging (MRI) Emergency Response Preparedness. The target date for completion of training is October 27, 2014. A sign in sheet will be used to document completion of the training.

Learning Resources is taking on the task of making the Level 2 DVD training 508 compliant so that it can be added to the VA Talent Management System (TMS) for future trainings. The estimated installation date into TMS is on or before of November 1, 2014. Once the training program is entered into TMS, the sign in sheets will be used to permanently record the employee training in TMS.

Level 1 MRI training is already completed annually at the facility. Level 2 training will added as an annual training and will be reviewed annually by the MRI Lead Technologist, and monitored by the Imaging Manager and Chief of Radiology.

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VHA Handbook 1109.04, *Food Services Management Program*, October 11, 2013.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

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

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