Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-01447-68

Combined Assessment Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina

February 17, 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 22–26, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Fayetteville VA Medical Center (the medical center), Fayetteville, 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 148 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in four of the activities reviewed. For these activities, the medical center needed to ensure that:

- Facility Management Service (FMS) conducts facility-wide cleaning and monitors routine cleaning.
- Engineering Service monitors the timeliness of work order completion.
- Regular testing of the WanderGuard® system is documented.
- Clean linen is stored appropriately.
- Committee meeting minutes comply with medical center policy.
- The peer review process complies with medical center policy.
- The Utilization Management (UM) Committee meets as required.
- Moderate sedation outcomes are monitored and evaluated.
- Resuscitation outcomes are monitored.
- Medical record reviews are completed in accordance with Veterans Health Administration (VHA) policy.
- Discharge documentation is completed, as required by VHA policy.
- Privacy is maintained in the emergency room (ER).

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

- Medication Management.
- Patient Satisfaction.
- Pharmacy Operations.
- Staffing.

This report was prepared under the direction of Christa Sisterhen, former Associate Director, Atlanta 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 18–23, 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 a general medical and surgical facility located in Fayetteville, NC, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Midway Park, Wilmington, and Hamlet, NC. The medical center is part of VISN 6 and serves a veteran population of about 171,800 throughout 21 counties in southeastern North Carolina and 2 counties in northeastern South Carolina.

Programs. The medical center provides primary, specialty, and long-term care services. It has 90 hospital beds and 69 community living center (CLC)[1] beds.

Affiliations. The medical center is affiliated with local institutions and provides training for dental residents, nursing students, and other allied health professionals.

Resources. In FY 2007, medical care expenditures totaled $121 million. The FY 2008 medical care budget was $122 million. FY 2007 staffing was 868 full-time employee equivalents (FTE), including 68 physician and 243 nursing FTE. FY 2008 staffing data was not available at the time of our review.

Workload. In FY 2007, the medical center treated 42,717 unique patients and provided 14,144 inpatient days in the hospital and 21,205 inpatient days in the CLC. The inpatient care workload totaled 2,178 discharges, and the average daily census, including CLC patients, was 98.2. Outpatient workload totaled 340,478 visits. FY 2008 workload data was not available at the time of our review.

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.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- 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 eight activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- Pharmacy Operations.
- QM.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through September 22, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Fayetteville, North Carolina,* Report No. 05-02813-40, December 12, 2005). 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 148 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 that required corrective actions.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if VHA medical centers maintain a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the locked mental health unit, the pharmacy, two CLC units, the ER, and the acute care unit. We found that the medical center had corrected the EOC findings from our prior CAP review. The infection control (IC) program monitored exposures and reported data to clinicians for implementation of quality improvements.

Overall, we found that the medical center maintained a safe environment. However, we identified inadequate cleaning and maintenance as evidenced by visible dust and dirt on floors, equipment, and vents. We also noted stained and/or damaged ceiling tiles, the need for cosmetic repair of walls in some areas of the facility, missing escutcheons,[2] broken light covers, and burned out light fixtures. We identified the following unit-specific deficiencies.

<u>Locked Mental Health Unit</u>. VHA required each medical center to conduct rounds on their locked mental health unit using the Mental Health Environment of Care Checklist (MHEOCC)[3] and submit the results to the appropriate VISN Director by October 2007. The medical center's Multidisciplinary Safety Inspection Team identified hazards on the MHEOCC, such as adjustable beds, door handles, and faucets that could serve as anchor points for suicide attempts and suspension ceilings where contraband could be hidden. The MHEOCC dated August 1, 2008, noted 16 hazards from the first MHEOCC that were still being

[2] Escutcheons are protective plates or flanges placed around sprinklers that enclose holes cut in ceiling tiles thereby preventing heat, smoke, and fire from traveling through the hole and entering the space above.
[3] Tool used for assessing environmental risks to eliminate factors that could contribute to the attempted suicide or suicide of a patient or harm to staff members.

addressed and identified 3 new hazards, 1 of which was corrected while we were onsite.

Managers told us that construction of a new psychiatric unit is in the design phase and that this unit will have numerous safety improvements which will meet the recommended guidelines outlined in the MHEOCC. They also told us that new solid core beds are on order and that they are using additional staff to monitor patients until the hazards are corrected. We reviewed staffing sheets for the locked mental health unit and validated that overtime was being used to provide increased observation pending the construction of the new psychiatric unit. Because managers had already taken appropriate actions, we did not make a recommendation.

We found problems with work orders submitted to correct some of the identified hazards, such as door handles and fan coil filters. One work order remained incomplete after 4 months, and staff told us that others had been closed as completed even though the work had not been performed.

We found a suicide prevention poster displayed in only one highly visible area of the medical center. A Deputy Under Secretary for Health for Operations and Management memorandum issued on December 7, 2007, requires that posters be displayed in highly visible areas throughout the medical center. The Suicide Prevention Coordinator told us that poster frames ordered as part of the "halls and walls" beautification project had not yet arrived. She had previously distributed posters and brochures to nurse managers and planned to meet with management to discuss display solutions. Since the Suicide Prevention Coordinator had already taken action on this issue, we did not make a recommendation.

Pharmacy. We found that the pharmacy freezer needed to be cleaned and defrosted. Also, a pharmacy refrigerator leak had not been repaired despite two work order entries since May 2008. Additionally, work orders to spot weld an external pharmacy door hinge—cited in a December 3, 2007, physical security survey—remained incomplete.

Community Living Center. CLC staff told us that they conducted regular testing of the WanderGuard® system, but they did not have documentation of the testing. The WanderGuard® system is designed to prevent unauthorized

exit by patients at risk of harm when unsupervised. The JC requires that medical equipment be maintained and tested regularly for functionality. Without documentation of appropriate alarm testing, managers could not be assured that alarms would function in the event of a patient's unauthorized exit.

We found clean linen on the floor of the clean linen storage room, which poses a risk for the spread of infection. The JC requires that the risk of health care associated infection be minimized through an organization-wide IC program. As part of the program, clean linens must be handled, transported, and stored appropriately to be kept free of contamination.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that FMS conduct a facility-wide cleaning project and increase monitoring of routine cleaning.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they completed the facility-wide cleaning project. Schedules have been created for routine cleaning and for cleaning floors and equipment. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that Engineering Service monitors the completion of work orders for timeliness.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they will classify all work orders to determine priority. Results of tracking completed work orders for timeliness will be reported monthly at EOC Committee meetings. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires documentation of regular testing of the WanderGuard® system.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they have created a log to document testing of the WanderGuard®

system. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that clean linen be stored appropriately.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they will have nurse managers conduct random checks to ensure that linen is stored properly. Results will be reported to the Nurse Executive Committee. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management

The purpose of this review was to determine whether: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed the QM self-assessment regarding compliance with QM requirements. Also, we evaluated documents related to the functioning of the Quality Leadership Team, the Clinical Council, and the Medical Executive Board (MEB) and, we reviewed committee minutes and other relevant QM documents.

The QM program was generally effective in its oversight of the quality of care provided at the medical center, and managers supported QM efforts. The QM program was in compliance with standards in the following areas: (a) mortality reviews and analysis, (b) patient complaints, (c) adverse event disclosure, (d) patient safety, (e) medication reconciliation, (f) blood products usage reviews, (g) restraint usage, and (h) system redesign/patient flow. However, we identified deficiencies in the following areas:

Quality Management Committees. Committee minutes were generally narrative and did not consistently reflect data analysis, action tracking, or effectiveness monitoring. Medical center policy provides a recommended format for

meeting minutes that includes presentation of statistical data as well as conclusions, recommendations, actions, and effectiveness of actions. Critical Care Committee minutes did not include data analysis, and Patient Satisfaction Committee minutes did not reflect that actions were tracked to resolution or that effectiveness of actions was discussed. Without systematic data analysis and evaluation of actions taken, managers could not be assured that performance improvement activities were effective.

Peer Review. Peer review data were not trended or presented to the required oversight committee. Medical center policy requires presentation of a quarterly report to the MEB. This report should include the number of peer reviews, levels of outcomes, number of changes from one level to another, follow-up for action items, and recommendations resulting from completed peer reviews. In addition, Peer Review Committee minutes did not consistently reflect referral of system issues for further action and follow-up. Without regular reporting of peer review trends and activities, medical center managers could not be assured that peer reviews resulted in patient care improvements.

Utilization Management. The UM Committee had not met since December 2007. Medical center policy requires six committee meetings each year to review and evaluate utilization review information. The committee's responsibilities include systematic monitoring and evaluation of the overall appropriateness, efficiency, and effectiveness of resource utilization throughout the medical center. Since the committee had met only once during FY 2007, this critical review function did not occur. Without appropriate evaluation, managers could not be assured that improvement activities were initiated when indicated.

Operative and Other Procedures Reviews. The medical center did not monitor or evaluate moderate sedation usage during FY 2008. Medical center policy outlines the responsibility to review moderate sedation monitors. VHA policy[4] requires that moderate sedation outcomes, including the use of reversal agents, be monitored and analyzed to improve patient safety. Without appropriate data analysis,

[4] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2006.

managers could not be assured that corrective actions were initiated when indicated.

Review of Resuscitation and Its Outcomes. The medical center did not collect data to measure resuscitation performance and outcomes. The Critical Care Committee met during FY 2008 but did not present resuscitation data. The JC requires medical centers to collect data on resuscitation and outcomes. Without adequate resuscitation data collection and analysis, medical center managers would not be aware that improvement efforts were necessary.

Medical Record Reviews. Medical record reviews did not include all required monitoring of documentation in the electronic medical record. VHA policy[5] requires ongoing review of patient records at the point of care regularly over time. The medical center's medical record reviews did not consistently include monitors to assess the following: (a) presence of documentation, (b) proper format, (c) authentication, and (d) timeliness. In addition, VHA policy requires monitoring of copying and pasting in the electronic medical record. Medical center policy did not include monitors for the copy and paste functions, and the medical center did not conduct any monitors of these functions during FY 2008. Without evaluation of medical record documentation, medical center managers could not be assured that important aspects of patient care were documented and that the copy and paste functions were used appropriately.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that committee meeting minutes comply with medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they changed medical center policy and established a new meeting minute format that will include analysis, action tracking, and monitoring. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the peer review process complies with medical center policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and stated that they will report peer review activities to the MEB, the VISN Chief Medical Officer, and the VISN QM Officer. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires the UM Committee to meet as required.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they re-established the UM Committee and that the committee will meet six times a year. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation outcomes are monitored and evaluated.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they have added moderate sedation monitors as standing agenda items for Operative and Invasive Procedure Committee meetings. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that resuscitation outcomes are monitored.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they have completed a review of all resuscitation data. Data will be reported monthly at Critical Care Committee meetings. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews are completed in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they updated medical center policy and revised the review tool. Aggregated review findings will be presented at quarterly Medical Records Committee meetings. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met medical center, VHA, and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 11 inpatients who had consultations ordered and performed. Although the medical center had not established timeframes for inpatient consultations, patients were generally evaluated within 24 hours. We reviewed seven intra-facility transfers and found appropriate physician transfer orders and sending and receiving unit nursing notes in all of the records reviewed. We also found that all seven patients received timely nursing assessments on the receiving units. We identified one area that needed improvement.

Discharges. We reviewed 12 discharges. In all of the records reviewed, we found documentation that patients received copies of their discharge instructions and verbalized understanding of those instructions. However, we found the following inconsistencies in the information contained in discharge documentation:

- Not all discharge instructions included the patient medication list.
- Not all discharge summaries contained all the elements required by VA policy[6] such as discharge medications.

[6] VHA Handbook 1907.01.

- Some discharge summaries reflected inpatient medications instead of outpatient medications.

In addition, we found that discharge summaries were completed for only 11 of the 12 patients. Medical center policy requires that physicians complete and authenticate discharge summaries within 30 days of the patient's discharge. At the time of our site visit, one patient, discharged June 3, 2008, had no discharge summary in the computerized patient record system. Complete and timely documentation of patient health information enhances continuity and coordination of care.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that discharge documentation is completed, as required by VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they updated the discharge instruction template to include all outpatient medications. The discharge summary process will be monitored, and results will be reported quarterly to the Medical Records Committee. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether the medical center's ER complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and nursing staff competency. In addition, we inspected the ER environment for cleanliness and safety.

The ER is located in the main hospital building and is open 24-hours-per-day, 7-days-per-week, as required for ER designation. The emergency services provided are within the medical center's patient care capabilities. In addition, the medical center has a procedure in place for management of patients whose care may exceed the medical center's capability.

We reviewed the medical records of five patients who presented to the ER with acute mental health conditions and found that all five patients were managed appropriately. We also reviewed the medical records of three patients who were transferred out of the ER and found that transfers complied with medical center policy. We determined that nurse staffing plans met local requirements and that nursing

competencies were appropriately documented. We examined three pieces of medical equipment and found that preventive maintenance was completed, as required.

We toured the ER and found the environment to be safe for the delivery of patient care. However, we observed that the patient bathroom needed deep cleaning. The medical center began the cleaning process while we were onsite; therefore, we made no recommendation for this finding. We identified the following area that needed improvement.

Privacy. Privacy was not afforded to all patients in the ER. We toured the ER and observed a patient who was in obvious discomfort lying on a stretcher in an open area without doors, screens, or curtains for privacy. The JC requires that medical centers respect patients' needs for confidentiality, privacy, and security. Construction of a new ER is planned, but due to inadequate space in the current ER, the medical center places overflow patients on stretchers in the open area. While we were onsite, managers placed a portable privacy screen in the ER. This will allow overflow patients to have visual privacy when needed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that privacy is maintained in the ER.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they purchased additional privacy screens for use in the ER and re-educated staff on patient privacy and confidentiality. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed medication management processes on the acute inpatient medicine and surgery unit, the intensive care unit, the mental health unit, and two CLC units. We found that:

- Nurses utilized the Bar Code Medication Administration system and correctly identified patients prior to medication administration.
- Documentation of the effectiveness of PRN (as needed) doses of pain medication occurred within the required timeframe 96 percent of the time over the 6-day period we reviewed.
- A VISN 6 pharmacist was available to remotely review medication orders written after hours. These orders were then reviewed by a medical center pharmacist the following morning.

We made no recommendations.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients.

The purpose of this review was to assess the extent that VHA medical centers use SHEP data to improve patient care, treatment, and services. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

The graphs on the next page show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure results for outpatients, and Figure 2 shows the medical center's SHEP performance measure results for inpatients.

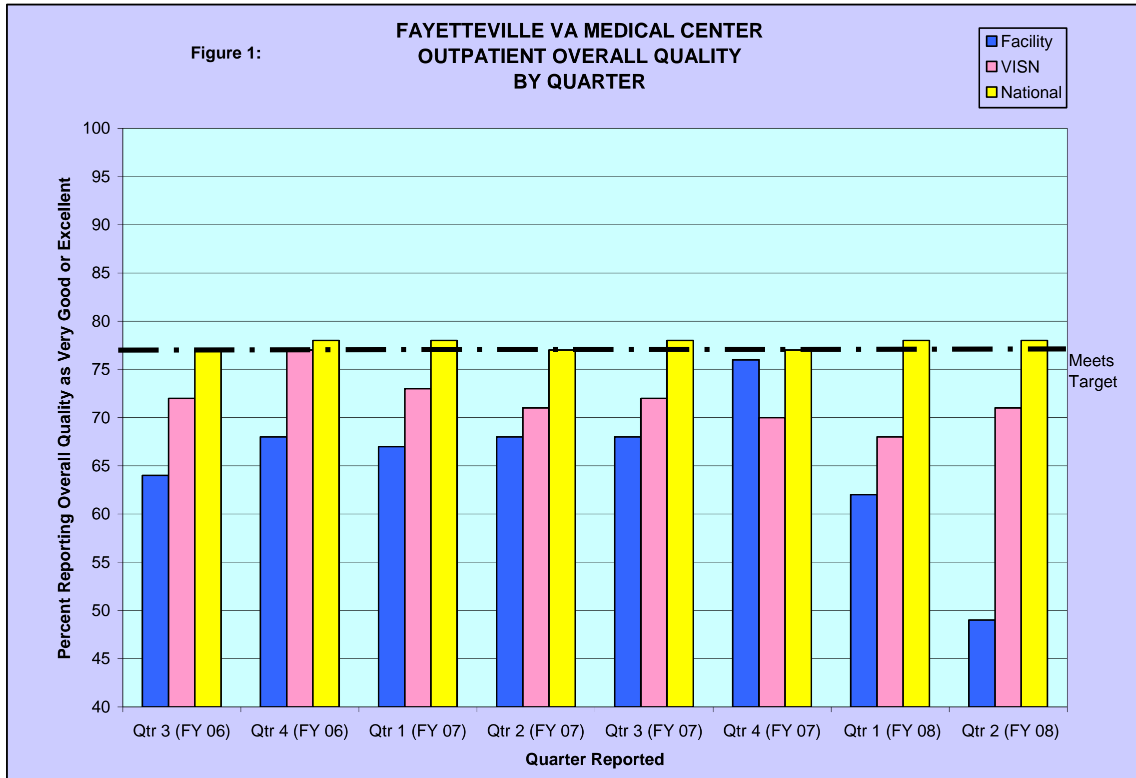
Figure 1:
FAYETTEVILLE VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
55
50
45
40
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

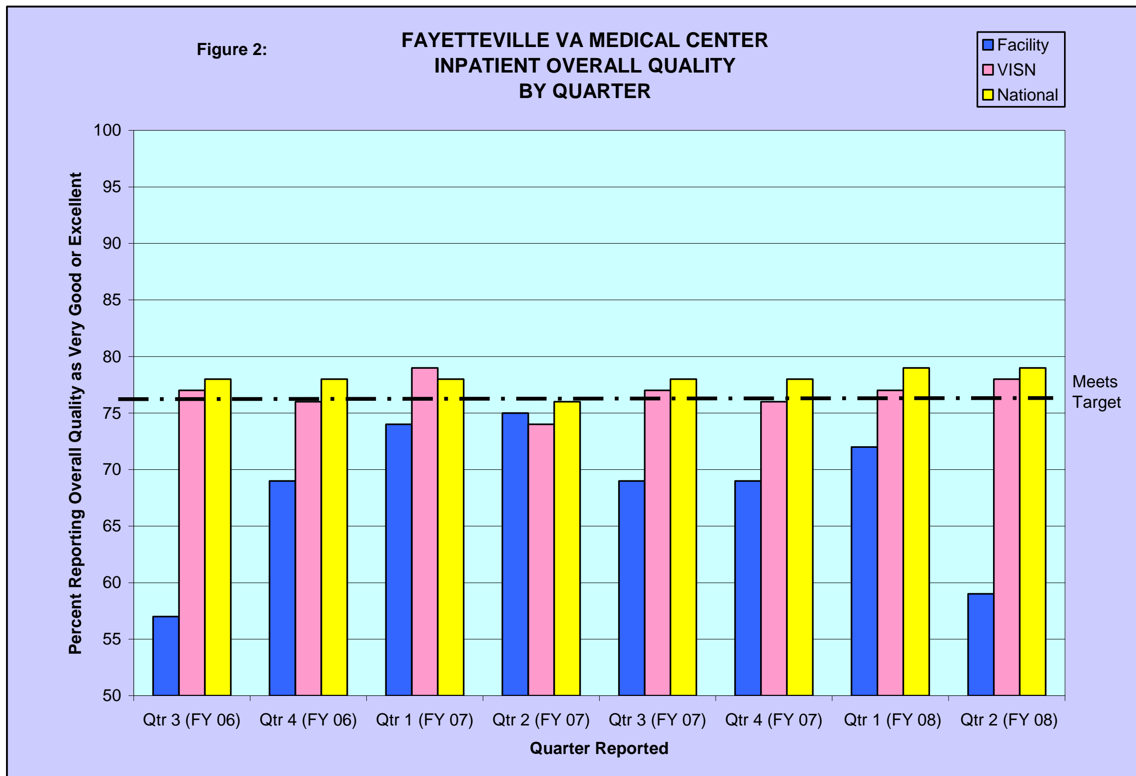
Figure 2:
FAYETTEVILLE VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
55
50
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

The medical center's outpatient SHEP scores for the 3rd quarter of FY 2006 through the 2nd quarter of FY 2008 were lower than national scores in all 8 quarters reported and did not meet the target. Inpatient scores for the 8 quarters were also below national scores and did not meet the target. However, the medical center was working to improve patient satisfaction and address patient concerns, such as inadequate parking, terminal cleaning, and courtesy.

The Patient Satisfaction Committee is coordinating efforts to target deficiencies. Several initiatives have been implemented, including the following:

- Follow-up calls and "thank you" notes to discharged patients.
- Valet parking.
- Increased customer service training for employees.

The medical center uses "quick card" surveys to measure patient satisfaction immediately following discharge or an outpatient clinic visit and reported that their scores showed patient satisfaction to be higher than reflected by SHEP scores. Since the medical center has already taken appropriate actions, we made no recommendations.

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances and to inspect the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations[7] governing pharmacy and controlled substances security, and we assessed whether the policies and practices of the medical center were consistent with VHA regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service and Police and Security Service personnel as necessary. We also reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists

[7] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

monitored patients prescribed multiple medications to avoid polypharmacy.

We found that the medical center had appropriate policies and procedures to ensure the security of the pharmacies and controlled substances. Controlled substances inspections were conducted in accordance with VHA regulations. Training records showed that the Controlled Substances Coordinator and inspectors received appropriate training to execute their duties. We also found that managers reported all controlled substances diversions or suspected diversions to the OIG. The clean room,[8] where sterile intravenous medications were prepared, met established standards.

Pharmacological regimens involving multiple medications are often necessary to prevent and treat disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. Polypharmacy is defined as: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[9] Some literature suggests that elderly and mental health patients are among the most vulnerable populations for polypharmacy.[10]

Our review showed that managers developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate. We made no recommendations.

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that

[8] A room in the inpatient pharmacy where the concentration of airborne particles is controlled by proper construction and controlled temperature, humidity, and air pressure.
[9] Yvette C. Terrie, BSPharm, RPh, “Understanding and Managing Polypharmacy in the Elderly,” *Pharmacy Times,* December 2004.
[10] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., “Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital,” *Psychiatric Services*, 57:21–23, January 2006.

the medical center had developed adequate staffing guidelines for nurses.

The number of nursing care hours relative to patient workload is defined as hours per patient day (HPPD). The medical center uses the HPPD staffing model to determine staffing levels and mix of registered nurses, licensed practical nurses, and nursing assistants. The Nursing Executive Council tracks and trends staffing data and reviews the data at least annually.

We reviewed nurse staffing for five inpatient units and the ER for 3 different days. The days included one holiday, one weekend day, and one weekday. We found that staff levels met or exceeded the requirements for 17 (94 percent) of the 18 total days. Nurse managers reported having sufficient nursing staff to meet patient needs and stated that they had no difficulties recruiting nurses when vacancies occurred. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs

Date: December 30, 2008

From: Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subject: **Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina**

To: Associate Director, Atlanta Regional Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

1. Thank you for the opportunity to respond.

2. The Fayetteville VAMC concurs with the findings, and has provided specific corrective actions for each recommendation.

3. If further information is required, please contact Bruce Triplett, Director, Fayetteville VA Medical Center at (910) 822-7039.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2008

From: Director, Fayetteville VA Medical Center (565/00)

Subject: **Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina**

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

Fayetteville VA Medical Center concurs with findings. We have provided the specific corrective actions we have taken for each recommendation.

(original signed by:)

Bruce Triplett

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 FMS conduct a facility-wide cleaning project and increase monitoring of routine cleaning.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. The pharmacy area was cleaned of dust and paper towels as of October 24, 2008. FMS has completed a facility wide cleaning project as of December 19, 2008. Additionally, a cleaning schedule has been created for routine cleaning. Deep cleaning of floors has been place on a quarterly schedule and cleaning portable vital sign machines is scheduled to occur weekly. Monitoring of these actions will be incorporated into routine EOC rounds.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that Engineering Service monitors the completion of work orders for timeliness.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. FMS has established a hierarchy for completion of work orders. Items are classified as emergency, environment of care list items, or routine maintenance items, etc. These definitions are outlined in MCM138-3, Requests for Maintenance & Repair (M&R) Work. These criticalities are monitored accordingly for completion, and reports are generated showing completion dates for all emergency or environment of care items. Records are maintained in the work order system for all noncritical work order items. Tracking for timeliness of completion of these orders will be reported at the monthly EOC committee meetings.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires documentation of regular testing of the WanderGuard® system.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. As of November 3, 2008, a daily log of the WanderGuard® system testing was implemented. The Associate Chief Patient Care Services – Long-Term Care has overall responsibility. Monitoring of compliance will be reported to the Nurse Executive Committee.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that clean linen be stored appropriately.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. Nurse Managers or designee conduct random checks, at a minimum of 3 to 5 times a week, to ensure linen is stored properly. Results are reported at the Nurse Executive Committee.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that committee meeting minutes comply with medical center policy.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. A new minute format was established on 10/17/08. Staff members were educated accordingly. This new format has been implemented and is currently in use by all committees. A change to corresponding medical center policy was also completed. Minutes now contain analysis, action tracking, and monitoring.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the peer review process complies with medical center policy.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. Quarterly Peer Review activities are currently being reported to the Medical Executive Board and the VISN Chief Medical Officer (CMO) and VISN Quality Management Officer (QMO). Additionally, "Peer Review – Systems Issues" has been added as a standing agenda item for the Medical Executive Board.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires the UM Committee to meet as required.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. The committee, chaired by the Utilization Management Coordinator, has been re-established. The Committee will meet six (6) times a year and/or at the call of the Committee Chairperson. A meeting was conducted on December 18, 2008.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation outcomes are monitored and evaluated.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. Moderate Sedation has been added as a standing

agenda item to the quarterly “Operative & Other Invasive Procedure” meetings. This change was effective October 2008. Sub-topics now included are:

- Use of reversal agents
- Critical analysis of moderate sedation data
- Data comparison with internal or external benchmarks
- Opportunities for improvement
- Action item follow-up

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that resuscitation outcomes are monitored.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. An annual review of all resuscitation data was completed in September 2008. A plan for daily capturing of code sheets including adequacy of other data related to codes was established. The data will be reported at the monthly Critical Care Committee meetings.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews are completed in accordance with VHA policy.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. An updated review tool that incorporates reviews of physician orders, pain level, problem list, and monitoring of “copy and paste” has been created. As of December 30, 2008, both the tool and MCM 00-113 Medical Records Committee policy have been updated and approved by the Medical Records Committee. Clinical services will monitor this process monthly. Findings will be aggregated and reported to the Medical Records Committee on a quarterly basis.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge documentation is completed, as required by VHA policy.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. VHA Directive 1907.01 and Medical Center Policy “136-17 Medical Record Documentation & Completion” was distributed to all clinical staff. All requirements were highlighted and discussed at Medical Staff meetings. Additionally, the discharge instruction template has been adjusted to automatically incorporate outpatient medications. These are now included in the discharge template. Clinical services will monitor this process monthly. Findings will be aggregated and reported to the Medical Records committee on a quarterly basis.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that privacy is maintained in the ER.

Response: The VISN and FVAMC Director concurred with the findings and recommendation. Patient privacy screens were purchased and are currently in use since December 22, 2008. Nursing staff in the ED have been educated on patient privacy and information security. They have also been advised to use low voices when discussing patient care needs to help preserve patient confidentiality.

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