Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00916-204

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

September 15, 2008

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.

Table of Contents

Executive Summary

Introduction

During the week of June 9–12, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Hampton VA Medical Center (the medical center), Hampton, VA. 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 180 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered five operational areas and activities. We identified the following organizational strengths:

- Information Security and Privacy.
- Respiratory Hygiene.

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to comply with Veterans Health Administration (VHA) policies and guidance regarding:

- Locked mental health unit safety.
- Construction barriers.
- Credentialing and privileging (C&P) processes.
- Cardiopulmonary resuscitation (CPR) certification.
- Mortality review processes.
- Root cause analysis (RCA) processes.
- Adverse event disclosure.
- Pharmacy clean room ceilings.
- Pharmacy clean room door switches.
- Pharmacy chemotherapy room light switches.

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

- Emergency Department (ED).
- Patient Satisfaction.

This report was prepared under the direction of Christa Sisterhen, 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 16–20, for the full text of the Directors' comments.) We will follow up on the proposed 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 provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at one community based outpatient clinic in Virginia Beach, VA. The medical center is part of VISN 6 and serves a veteran population of about 220,000 throughout a 15-county region in eastern Virginia and northeastern North Carolina.

Programs. The medical center provides primary, specialty, and long-term care services. It also provides spinal cord injury and palliative care services. The medical center has 177 hospital beds and 122 community living center (CLC)[1] beds.

Affiliations and Research. The medical center is affiliated with Eastern Virginia Medical School and provides training for 50 medical residents, as well as other allied health disciplines, including nursing, dental, pharmacy, social work, dietetics, and psychology. In fiscal year (FY) 2007, the medical center research program included 22 projects and had a budget of $1.1 million. Important areas of research include substance abuse, smoking cessation, prostate cancer, and post-traumatic stress disorder.

Resources. In FY 2007, medical care expenditures totaled $161.6 million. The FY 2008 medical care budget is $176.1 million. FY 2007 staffing was 1,239 full-time employee equivalents (FTE), including 72 physician and 341 nursing FTE.

Workload. In FY 2007, the medical center treated 30,382 unique patients and provided 42,540 inpatient days in the hospital and 30,539 inpatient days in the CLC. The inpatient care workload totaled 2,299 discharges, and the average daily census, including CLC patients, was 200. Outpatient workload totaled 293,084 visits.

Objectives and Scope

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

[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.

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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

- ED.
- Environment of Care (EOC).
- Patient Satisfaction.
- Pharmacy Operations.
- QM.

The review covered medical center operations for FY 2007 and FY 2008 through June 9, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Hampton, Virginia,* Report No. 05-00115-136, May 6, 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 180 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant

enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Organizational Strengths

Information Security and Privacy

The medical center created a team called the Information Security and Privacy Review Team (ISPRT) to identify opportunities for improvement in the areas of privacy and cyber security throughout the medical center. The ISPRT consists of the Information Security Officer, the Privacy Officer, the Chief Information Officer, a physical security specialist, the Chief of Health Information, and a QM representative. The team utilizes a checklist to assess areas of the medical center for information security and privacy vulnerabilities. They develop action plans and work with area managers to correct deficiencies and mitigate identified risks. The team also responds to all incidents related to breaches of information security. The medical center received an award from the Deputy Assistant Secretary of Information Protection and Risk Management of the Office of Information and Technology for the development of this team.

Respiratory Hygiene

The medical center was proactive in establishing Respiratory Hygiene/Cough Etiquette Stations as a way of implementing the Centers for Disease Control and Prevention guidelines to control the spread of respiratory infections among patients, visitors, and health care staff. The infection control (IC) team placed stations throughout the medical center in response to a local outbreak of tuberculosis at two community hospitals and as preparation for a potential influenza pandemic. The focal point of each station is a poster entitled "Infection: Don't Pass It On," which promotes hand hygiene and mouth covering when coughing or sneezing. The stations contain hand hygiene sanitizer, tissues, and masks and are located throughout the medical center. There are tabletop versions in all waiting areas. The stations have been well received and are utilized by veterans, visitors, and staff.

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 acute medical inpatient unit, the medical intensive care unit, the locked mental health unit, the palliative care unit, the substance abuse rehabilitation unit, the chemotherapy unit, the dialysis unit, the emergency room, and the primary care clinics. We found that the medical center was generally clean and well maintained and had corrected the EOC findings from our prior CAP review. The IC program monitored exposures and reported data to clinicians for implementation of quality improvements. However, we identified deficiencies related to patient and staff safety on the locked mental health unit and to a construction barrier on the palliative care unit.

Locked Mental Health Unit. The medical center's Multidisciplinary Safety Inspection Team conducted rounds on the locked mental health unit and completed the Mental Health Environment of Care Checklist (MHEOCC),[2] as required by VHA. The MHEOCC dated June 9, 2008, identified 21 environmental safety hazards. For example, anchor points that could pose a risk of suicide by hanging (vanity lights, shower knobs, toilet paper dispensers, and side mounted sprinkler heads) and objects that could be used for cutting (rough door edges) or as weapons (loose tiles and radiator covers) were accessible to patients. Managers presented us with an abatement plan, which was ongoing at the time of our visit. They also implemented patient observations every 30 minutes to minimize the risk for harm until corrective actions were completed. Therefore, we did not make any recommendations for these findings.

We found that 8 of 13 duress (panic) alarms on the locked mental health unit were inoperable (non-functioning or could not be reset). Two of these inoperable alarms were located in the two female patient rooms, which were occupied at the

[2] Tool used for the purpose of assessing environmental risks to eliminate factors that could contribute to the attempted suicide or suicide of a patient or harm to staff members.

time of our visit. Also, we determined that medical center police did not follow their own policy, which required monthly testing of duress alarms and documentation of test results. The System Wide Ongoing Assessment and Review Strategy (SOARS)[3] report from the January 2007 site visit found that the duress alarms rang on the unit instead of in the police department. We reviewed the abatement plan, which showed that the issue was resolved and that the alarms sounded in the police communication section. We questioned this after learning that staff were still confused about where some alarms rang, and the Chief of Police told us that he was unaware that duress alarms were installed anywhere other than the nursing stations. We tested the alarms and found that not all of the working alarms rang in the police department. Without appropriate testing, managers could not be assured that the alarms would function in an emergency.

Additionally, we found that the existing duress alarms were wall-mounted instead of attached to furniture where they would be easily accessible, as recommended in medical center policy. In most of the staff offices, the alarms were mounted next to the door, and the desks were located on the opposite side of the room. Managers told us that they had purchased handheld panic alarms; however, some staff were not aware that these were available.

In the event of an emergency, duress alarms should be available and easily accessible to staff. While we were onsite, managers presented us with an action plan to: (1) repair all inoperable duress alarms, (2) conduct monthly testing of alarms, (3) relocate duress alarms in staff offices, and (4) educate all staff regarding location of duress alarms and availability of handheld alarms.

Palliative Care Unit. We found a seal on a construction barrier on the palliative care unit that was not intact. According to the IC risk assessment,[4] the area should have been sealed to control environmental dust. Staff told us that they entered the construction area to get linen for patient care from the linen closet. Managers placed a linen cart outside of the construction area while we were onsite.

[3] SOARS is a VHA program providing educational and consultative services to medical centers in preparation for external reviews.

[4] Tool used for the purpose of assessing environmental risks to minimize patients' exposure to factors that could contribute to airborne related respiratory problems.

Controlling environmental dust reduces patients' risk for dust-related respiratory problems.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all corrective actions for the duress alarms on the locked mental health unit be completed.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the duress alarms will be repaired or replaced, relocated for easy access, and tested. Continuing staff education will be provided. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure the Medical Center Director requires that all construction barriers are intact so that clinical staff cannot enter construction sites.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the construction barriers have been sealed and will be monitored daily and that signage has been improved. We will follow up on the actions to ensure completion.

Quality Management

The purposes of this review were to determine if: (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 self-assessment completed by QM staff regarding compliance with QM requirements. We also evaluated documents related to the functioning of the Medical Executive Board and the Performance Improvement Board as well as other relevant QM documents and committee minutes.

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 areas of medication

reconciliation, blood products usage, operative and other procedures, resuscitation outcomes, restraint and seclusion, patient flow, and medical records. However, we identified deficiencies in the following program areas:

Credentialing and Privileging. VHA regulations[5] and JC medical staff standards require clinical managers to collect and review provider performance data as part of the medical staff reappraisal and reprivileging process. Privileges must be based on evidence of the physician's current competence. Therefore, the reappraisal data review should include physician-specific data, such as patient care outcomes or number of procedures performed.

We reviewed performance data contained in the C&P folders of four contract ED physicians. We found that some of the privileges granted to the physicians were not based on specific data that supported competency. Clinical managers told us that some privileges granted to the physicians were for procedures that had not been performed in the ED in the past 5 years. Without evidence of continued competency, clinical managers cannot be assured of a physician's ability to perform the procedures for which he/she has privileges.

Cardiopulmonary Resuscitation Certification. We found that 10 contract and fee basis surgeons and one certified registered nurse anesthetist (CRNA) did not have documentation of current CPR certification. VHA policy[6] states that all clinically active staff, including physicians and mid-level providers, must have current CPR certification. CPR certification ensures that health care providers are able to initiate appropriate and skilled emergency interventions to resuscitate patients. The medical center's CPR policy states that full-time and part-time physicians are required to have Basic Life Support certification and that CRNAs are required to have Advanced Cardiac Life Support certification. If providers are not CPR certified, managers cannot be assured that they are able to provide potentially life-saving procedures in a safe and effective manner to persons suffering life-threatening cardiopulmonary events.

Mortality Review. The mortality review screening process occurred, as required by VHA policy.[7] However, we found a

[5] VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007.
[6] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.
[7] VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

delay in the referral of cases for peer review. From October 1, 2007–June 9, 2008, we found that none of the seven mortality cases meeting criteria for peer review were referred for at least 89 days after the death occurred. Staff told us that they delayed referrals pending receipt of death certificates. Since these peer reviews were delayed, managers could not be assured that potential or actual adverse events were timely identified, which could result in missed opportunities to improve patient care.

Root Cause Analyses. We found that elements of the RCA process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA policy[8] requires (1) completion of RCAs within 45 days of the medical center's identification of need and (2) implementation of action plans and evaluation of outcomes to ensure that changes have the desired effect.

During FY 2007 and FY 2008 through May 14, 2008, the medical center initiated 11 individual RCAs and 2 of the 4 required aggregate RCAs. We found that:

- At the time of our visit, only one of the aggregate RCAs was completed.
- Individual RCAs had actions that were not tracked to completion and/or outcomes that were not evaluated for effectiveness.
- Eight individual RCAs were not completed within the 45-day timeframe.

Without an adequate RCA process, managers could not be assured that quality improvement actions were initiated in a timely manner to prevent recurrence of similar adverse events.

Adverse Event Disclosure. The medical center did not appropriately document clinical disclosures or evaluate events for possible institutional disclosure, as required by VHA policy.[9] Clinical disclosure is an informal process to discuss harmful events with patients and/or their families; physicians document clinical disclosure in progress notes. Institutional disclosure is a more formal process used in cases of serious injury, death, or potential legal liability and

[8] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, May 23, 2008.
[9] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*, January 18, 2008.

includes an apology and information about compensation and the procedures available to request it. Medical center managers should complete documentation of institutional disclosure using the required template in the computerized patient record system.

The medical center identified six clinical and four institutional disclosures which were conducted in FY 2007 and FY 2008 through May 14, 2008. We found that clinical staff used the institutional disclosure template rather than progress note documentation for the clinical disclosures. This type of disclosure is not appropriate at the clinical level and should only be completed when evaluation for disclosure determines that the medical center has responsibility for patient harm. We also found that clinical staff improperly conducted institutional disclosures. Institutional disclosures should be conducted by medical center managers in conjunction with input from regional counsel.

Without appropriate disclosure processes, managers could not be assured that disclosures were properly conducted and that patients received important medical and legal information needed to make decisions when adverse events occurred.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires the Medical Executive Board to develop a plan to review the privileges of all physicians to ensure that competencies are current.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the medical center has defined a process to review physician core competencies. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires all appropriate clinical staff to maintain current CPR certification, in accordance with VHA and medical center policy.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they will revise local policy, conduct CPR classes regularly, and hold supervisors accountable for staff compliance. The

implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that peer review referrals from the mortality screening process occur more timely.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they have initiated an improvement process to conduct reviews within 30 days. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that all elements of the RCA process be completed in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the RCA process has been reviewed and that plans for improvement have been initiated. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that disclosure processes comply with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the VHA template will be used for institutional disclosure only. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Pharmacy Operations

The purposes of this review were to evaluate the pharmacies' internal physical environments and to determine whether the medical center had adequate controls to ensure the security and proper management of controlled substances. We also evaluated whether clinical managers had processes in place to monitor patients who were prescribed multiple medications.

We reviewed VHA regulations[10] governing pharmacy and controlled substances security, and we assessed whether the medical center's policies and practices were consistent with these 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. Additionally, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications.

Pharmacy Controls. Our review showed that the medical center had appropriate policies and procedures to ensure the security of the pharmacies and controlled substances. Controlled substances inspections were conducted according to 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 pharmacies' internal physical environments were secure, clean, and well maintained.

Our review found that the clean rooms,[11] where sterile intravenous medications were prepared, were not in compliance with VHA regulations[12] and IC standards. We found that the clean room ceilings were not properly sealed and that the door to the main clean room and the light switch in the chemotherapy clean room were not automatic. These conditions could allow dust or other outside contaminants to enter the clean rooms or could allow for transfer of contaminants into or out of the clean, sterile environment.

Polypharmacy. 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. The clinical criteria to identify polypharmacy are the use

[10] 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.
[11] A clean room is a room located in an inpatient pharmacy where the concentration of airborne particles is controlled by proper construction and controlled temperature, humidity, and air pressure.
[12] VHA Handbook 1108.6.

of: (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.[13]

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.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires the clean room ceilings to be evaluated and properly sealed to meet requirements.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the clean room ceilings will be sealed. The implementation plan is acceptable, and we will follow up on the planned action until it is completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires installation of an automatic door switch leading into the main clean room.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that an automatic door switch leading into the clean room was installed. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires installation of an automatic light switch in the chemotherapy clean room.

The VISN and Medical Center Directors agreed with the finding and recommendation and installed an automatic light switch. The corrective action is acceptable, and we consider this recommendation closed.

[13] Yvette C. Terrie, BS Pharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.

Review Activities Without Recommendations

Emergency Department

The purpose of this review was to evaluate whether the medical center's ED complied with VHA guidelines[14] related to hours of operation, clinical capability, staffing adequacy, and nursing staff competency. In addition, we inspected the ED environment for cleanliness and safety.

The ED is located in the main hospital building and is open 24 hours per day, 7 days per week, as required for ED designation. 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 10 patients who presented to the ED with acute mental health conditions and found that all 10 patients were managed appropriately. We also reviewed the medical records of 10 patients who were transferred out of the ED 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. Also, we toured the ED and found the environment to be clean and safe for the delivery of patient care. 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.

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 purpose of this review was to assess the extent that VHA medical

[14] VHA Directive 2006-051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments,* September 15, 2006.

centers use SHEP data to improve patient care, treatment, and services.

The following graphs show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure (PM) results for inpatients. Figure 2 shows the medical center's SHEP PM results for outpatients.

Figure 1:

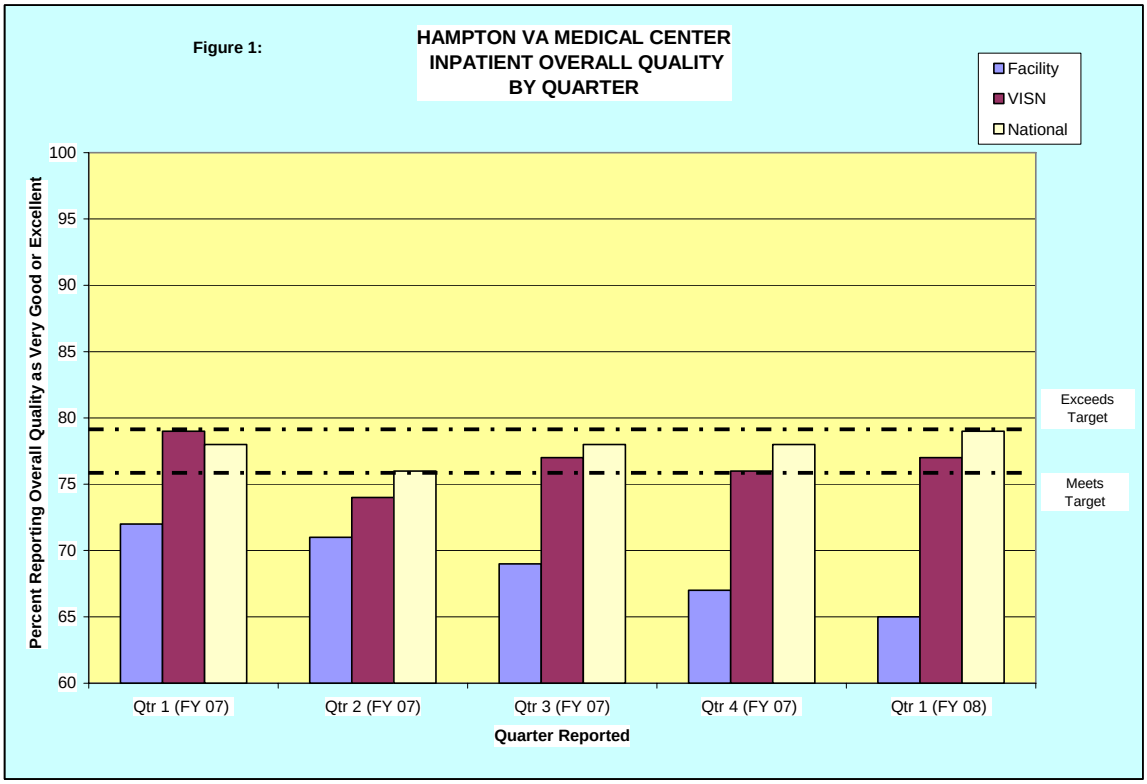
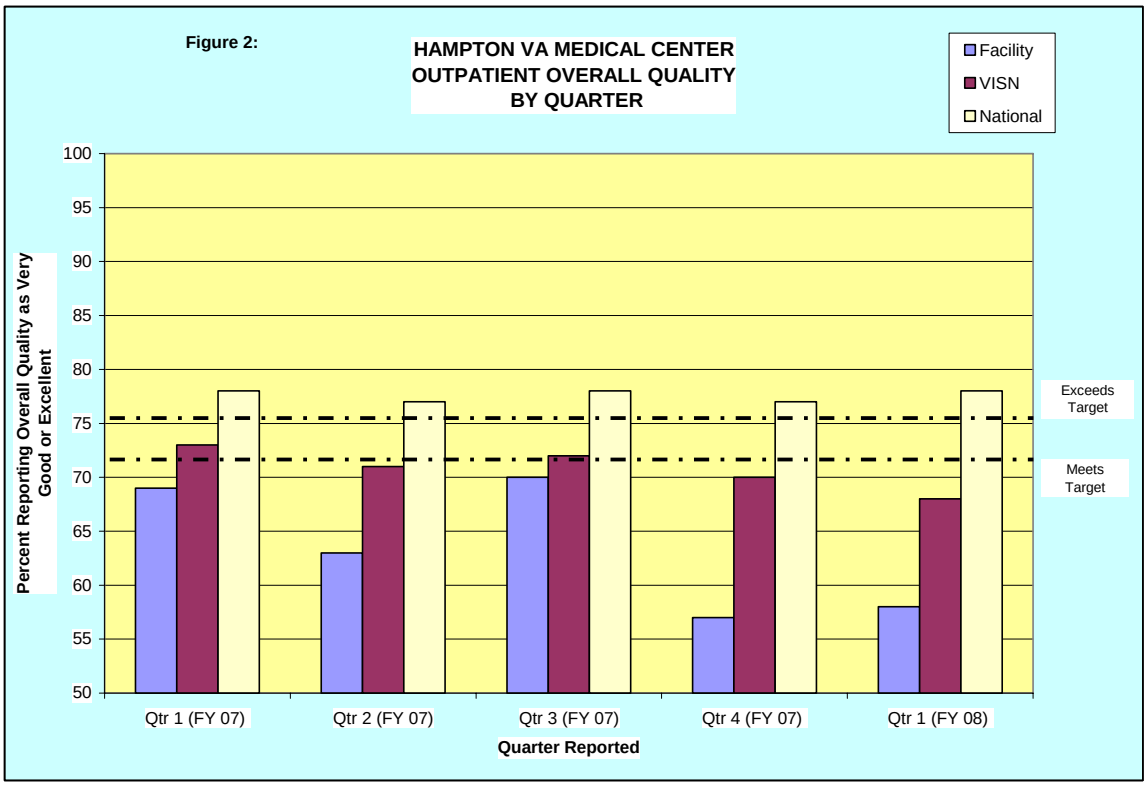


Figure 2:



The medical center's inpatient and outpatient overall SHEP scores for FY 2007 and the 1st quarter of FY 2008 did not meet established targets and were lower than national and VISN scores. However, the medical center was working to improve patient satisfaction. Their Customer Service Board (CSB) held a retreat, created a strategic plan, and implemented process action teams to address VISN initiatives to improve parking and telephone services. The CSB initiated orientation classes for outpatients and bedside chats and discharge follow-up calls for inpatients.

The medical center uses "quick cards" to measure patient satisfaction immediately following an encounter and reported that their scores showed patient satisfaction to be much higher than reflected by SHEP scores. Also, the medical center communicates patient satisfaction scores to staff on a regular basis. The CSB is now chaired by the medical center's Director, and the remaining members of the quadrad have key leadership roles. The medical center continues to review the effectiveness of its corrective actions and makes modifications as indicated. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2008

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

Subject: **Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia.**

To: Associate Director, Atlanta Healthcare Inspections Division (54AT)

Director, Management Review Service (10B5)

1. The Mid-Atlantic Health Care Network submits the following responses to recommendations resulting from the Office of Inspector General visit at the Hampton VA Medical Center on June 9–12, 2008. I concur with the findings, and the facility has initiated corrective actions.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2008

From: Director, VA Medical Center, Hampton, VA (590/00)

Subject: **Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia.**

Thru: Associate Director, Atlanta Healthcare Inspections Division (54AT)

Director, Management Review Service (10B5)

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

1. I have reviewed the draft report and concur with the findings. We have initiated corrective actions to address the findings.

2. Questions and concerns can be addressed to me at (757) 728-3100.

(original signed by:)

WANDA MIMS, MBA
Director, Hampton VA Medical Center

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that all corrective actions for the duress alarms on the locked mental health unit be completed.

Concur

Corrective actions have been implemented to include repair of duress alarm system, testing of system, and on-going staff education in use and testing processes. All defective devices have been replaced and new receivers have been installed. The mental health team has also assessed the furniture layout to determine optimal access to the alarm system. The alarms identified for relocation will be moved by 8/8/08.

Recommendation 2. We recommended that the VISN Director ensure the Medical Center Director requires that all construction barriers are intact so that clinical staff cannot enter construction sites.

Concur

Construction barriers have been completely sealed and monitored for compliance by the COTR daily. Improved signage has been initiated to prohibit unauthorized entry into construction zones.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires the Medical Staff Executive Board to develop a plan to review the privileges of all physicians to ensure that competencies are current.

Concur

The Medical Center has initiated a clearly defined process for Ongoing Professional Practice Evaluation (OPPE) which includes the following six core competencies:

1) Patient Care

2) Medical/Clinical Knowledge

3) Practice-based Learning and Improvement

4) Interpersonal and Communication Skills

5) Professionalism

6) Systems-based Practice

The outcomes of the OPPE and procedure specific data will be reviewed regularly by the Medical Executive Board. The COS will review findings with each service chief. The Emergency Department physician review will be completed by September 12, 2008. Triggers are established for identifying need for focus reviews.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires all appropriate clinical staff to maintain current CPR certification, in accordance with VHA and medical center policy.

Concur

A process has been implemented for review and revision of local CPR policy to ensure alignment with VHA Directive. CPR classes are conducted regularly and supervisory accountability of staff attendance at training is in place. All appropriate clinical staff will maintain current CPR certification.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that peer review referrals from the mortality screening process occur more timely.

Concur

Mortality Reviews are being initiated within 30 days of death. This process immediately began, following the OIG site visit.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that all elements of the RCA process be completed in accordance with VHA policy.

Concur

The Medical Center has a clearly defined process for completion of all elements of the RCA process within 45 days. The Medical Center Director's charter letters are distributed to the designated team members within 96 hours of the identified need for the RCA. Supervisors provide protected time for active participation of designated team members. Each RCA team’s timeline status and outcome evaluations are reviewed during the Executive Leaders Vital Signs meeting on a bi-weekly basis and during the monthly Patient Safety Enhancement Committee meeting.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that disclosure processes comply with VHA policy.

Concur

The Chief of Staff, Risk Manager, and Regional Counsel are part of the disclosure process, and the VHA directive template will be used for institutional disclosure only.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires the clean room ceilings to be evaluated and properly sealed to meet requirements.

Concur

The project for resealing the ceiling of this clean room is planned for completion by August 15, 2008.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires installation of an automatic door switch leading into the main clean room.

Concur

A project is in place to install the automatic access switch. Target date: August 15, 2008.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires installation of an automatic light switch in the chemotherapy clean room.

Concur

This action has been completed.

OIG Contact and Staff Acknowledgments

Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Contributors	Susan Zarter, Team Leader Nancy Albaladejo Deborah Howard Tishanna McCutchen Toni Woodard Molly King, Special Agent, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid-Atlantic Health Care Network (10N6)
Director, Hampton VA Medical Center (590/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Warner, Jim Webb
U.S. House of Representatives: Robert C. "Bobby" Scott

This report is available at http://www.va.gov/oig/publications/reports-list.asp.