Department of Veterans Affairs
Office of Inspector General

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

Report No. 05-03384-70 **February 2, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices 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 and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- 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 October 3–7, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center Asheville, North Carolina. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 6 fraud and integrity awareness briefings to 153 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

Results of Review

The CAP review focused on 10 areas. The medical center complied with selected standards in the following four areas:

- Accounts Receivable and Payable
- Contract Administration
- Information Technology Security
- Radiology and Laboratory Review

We identified five areas that needed management attention. To improve operations, the following recommendations were made:

- Comply with the Patient Safety Alert regarding bed rails.
- Ensure cleanliness of bathrooms.
- Improve controls over supply inventory management.
- Improve management of controlled substances inventory levels.
- Improve reconciliation of Government purchase card transactions.

We also made an observation concerning the All Employee Survey.

This report was prepared under the direction of Mr. James R. Hudson, Director, and Mr. Willie Toomer, Acting CAP Review Coordinator, Atlanta Audit Operations Division.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 9–14, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(original signed by:)

JON A. WOODITCH
Deputy Inspector General

Introduction

Medical Center Profile

Organization. VA Medical Center Asheville, North Carolina is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. The medical center is part of VISN 6 and serves a veteran population of about 188,000 in a primary service area that covers 19 counties in western North Carolina.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The facility has 112 acute care beds and 120 extended care beds, and operates a Home Based Primary Care Program and a Substance Abuse Residential Rehabilitation Treatment Program. The medical center provides care to Department of Defense (DoD) beneficiaries as part of the TRICARE (military health system) preferred provider network. Other sources of non-appropriated funds include VA/DoD sharing agreements to provide primary and specialty care for geographically remote active duty personnel and recruiters.

Affiliations and Research. The medical center is affiliated with Duke University School of Medicine and supports 15 residency positions in general surgery, orthopedics, vascular surgery, cardiac surgery, ophthalmology, ENT (ear, nose, and throat), urology, anesthesiology, and Certified Registered Nurse Anesthetist. The medical center also has affiliation agreements with seven colleges and universities involving eight different training programs. In fiscal year (FY) 2005, the medical center research program had 16 projects and $220,200 in funding from VA and non-VA sources. Important areas of research include cancer studies and cardiovascular diseases.

Resources. In FY 2004, medical care expenditures totaled about $137 million. The FY 2005 medical care budget was about $148 million, a 7.9 percent increase from FY 2004 expenditures. FY 2005 staffing totaled 1,099 full-time equivalent employees (FTE), including 73 physician FTE and 358 nursing FTE.

Workload. In FY 2005, the medical center treated 29,592 unique patients, and provided 30,718 days of inpatient care and 24,879 days of VA nursing home care. The inpatient care workload totaled 3,724 discharges; the average daily census, including nursing home patients, was 152. The outpatient care workload was 246,594 visits.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, QM, benefits, and financial and administrative controls.
- 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, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

The review covered medical center operations for the period October 1, 2002, through October 7, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. In performing the review, we inspected work areas; interviewed managers and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following activities:

Accounts Receivable and Payable	Government Purchase Card Program
All Employee Survey	Information Technology Security
Contract Administration	Quality Management
Controlled Substances Accountability	Radiology and Laboratory Review
Environment of Care	Supply Inventory Management

During this review, we also presented 6 fraud and integrity awareness briefings to 153 medical center employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement, false claims, conflicts of interest, and bribery.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–7). 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. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Follow-up on Previous CAP Recommendations

As part of our review, we followed up on the recommendations of our previous CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center Asheville, North Carolina*, Report No. 03-01404-161, August 14, 2003). In 2003, we found that the Medical Center Director needed to: (a) improve QM, (b) improve

management of controlled substances, (c) strengthen controls over controlled substances, (d) improve Automated Information Systems security, and (e) ensure that transcription services charges are verified. Our October 2005 CAP review found that the Medical Center Director had adequately addressed the recommendations cited in the prior CAP report.

Results of Review

Opportunities for Improvement

Quality Management – Patient Safety Alert Recommendations on Bed Rail Entrapment Needed Implementation

Condition Needing Improvement. The recommended actions outlined in VHA Patient Safety Alert, Bed Rail Entrapment, dated July 13, 2001, were not completely implemented. The alert specified that bed rail openings must be less than 4¾ inches in size on beds used for high-risk patients (frail, elderly, confused, or physically impaired). The alert required immediate retrofitting of non-conforming beds to meet the opening requirements. Within 120 days of the alert, the medical center was to inventory and clearly mark the non-conforming beds as entrapment risks.

The medical center did not immediately retrofit all non-conforming bed rails and did not inventory, identify, and mark all the non-conforming beds within the 120-day timeframe specified in the Patient Safety Alert. While medical center managers told us some non-conforming beds were retrofitted, they could not produce an inventory identifying current bed locations, or provide evidence that non-conforming beds were marked. During the Annual Workplace Evaluation (AWE) conducted in March 2005, the VISN Safety Officer found non-conforming beds in the intensive care units (ICUs). In response to the AWE finding, the medical center completed a review in April 2005 of all beds in use at the time, and reported ICU beds were in compliance; however, they also noted there were non-conforming beds in other areas of the medical center. It appears that many of those beds were not properly inventoried or marked. During our review, we found 8 of 10 medical ICU beds and 2 of 8 surgical ICU beds were not in compliance with the Patient Safety Alert. Medical center staff told us that on occasion, patients could transfer into the ICU in a non-conforming bed from another unit.

During our review, medical center staff inventoried acute care beds and permanently marked the 65 beds not meeting the specifications for bed rail openings. Clinical managers educated staff on the bed entrapment risk to ensure they do not place high-risk patients in non-conforming beds.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director bring all beds into compliance with the Patient Safety Alert.

The VISN 6 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that all non-compliant beds have been permanently and clearly identified, and that a bed replacement plan was completed and sent to the VISN for approval. We will follow up on the planned actions until they are completed.

Environment of Care – Cleanliness of Bathrooms on Surgical Ward 3W Needed Improvement

Condition Needing Improvement. Mildew was present around sinks and toilets in bathrooms on Ward 3W, an acute surgical unit. VHA policy requires patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We inspected four inpatient units and found three to be clean. However, on Ward 3W, the caulking around the sinks and toilets in 7 of 11 bathrooms inspected was black with mildew. This condition could pose an infection control risk for patients. The medical center corrected this condition during our site visit by replacing all of the caulking around the identified sinks and toilets.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires Environmental Management Service staff to maintain cleanliness in all bathrooms.

The VISN 6 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the caulking around the sinks and toilets was removed, and inspection for discoloration around sink and toilet caulk joints was added to the inspection checklist. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed Improvement

Condition Needing Improvement. Acquisition and Materiel Management Service (A&MMS) staff did not effectively use the Generic Inventory Package (GIP) system to manage inventory levels for inventory control points (ICPs). GIP inventory records did not accurately reflect inventory balances for the five ICPs tested.

The medical center's 12 ICPs had 3,836 inventory line items valued at about $1.3 million, as of June 30, 2005. We reviewed a sample of 65 stock items valued at about $273,000 from the 5 largest ICPs (Operating Room (OR), Supply Processing and Distribution (SPD), Cardiovascular Laboratory (CV Lab), Laboratory Service, and Engineering Service) and found that inventory records were not accurate for 52 items (80 percent). Balances for 37 items were overstated by about $94,000 (less stock on hand than recorded in GIP) and balances for 15 items were understated by about $15,500 (more stock on hand than recorded in GIP), a net difference of about $78,500. The results of the counts were as follows:

ICP	Items Counted	Number of Incorrect Balances	Accuracy Rate	GIP Inventory Value	Adjusted Value	Variance
OR	20	16	20%	$151,813	$125,819	$25,994
SPD	15	11	27%	16,581	14,686	1,895
Engineering	10	8	20%	12,808	6,946	5,862
CV Lab	10	8	20%	40,790	31,451	9,339
Laboratory	10	9	10%	51,014	15,565	35,449
Total	**65**	**52**	**20%**	**$273,006**	**$194,467**	**$78,539**

VA's minimum inventory accuracy rate of 90 percent was not met by any of the ICPs reviewed. This occurred because the staff did not post receipts and disbursements timely, some bar coding labels were missing, and some item nomenclature and units of issue needed updating in GIP.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) GIP records contain accurate inventory balances, (b) ICP stock usage is entered into GIP timely, (c) missing bar code labels are replaced, and (d) GIP records contain accurate nomenclature and units of issue information.

The VISN 6 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that a Logistic Officer was hired to oversee inventory control; and Logistic staff was scanning all items into GIP, fixing bar code labeling, and changing the units of issue. We will follow up on the planned actions until they are completed.

Controlled Substances Accountability – Management of Inventory Levels Needed Improvement

Condition Needing Improvement. Inventory levels of controlled substances were excessive. As of May 31, 2005, the main vault contained 156 controlled substances line items valued at about $33,200. During the period June 1, 2004, to May 31, 2005, we found that 126 line items (81 percent) valued at about $23,600 exceeded VHA's supply goals based on usage data.

VHA policy requires that pharmacies maintain routinely stocked items at levels consistent with anticipated usage. Since the Prime Vendor Inventory Management Program is based on Pharmacy Service's purchasing activities, it is necessary that the Pharmacy Service analyze drug usage in order to ensure inventory levels are appropriate. Pharmacy Service started implementing the Drug Accountability Process (DAP) in February 2005, and management agreed to start analyzing usage data for the drugs that DAP indicates have high costs in an effort to reduce excess inventory.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires Pharmacy Service to: (a) develop an effective method for establishing inventory levels based on stock usage and (b) reduce inventory levels.

The VISN 6 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that a plan was implemented that would increase the order schedule from weekly to twice weekly for certain controlled substances and Pharmacy staff is managing inventory levels based on the ABC system.[1] We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Transactions Needed Proper Reconciliation

Condition Needing Improvement. The medical center needed to ensure that cardholders reconcile purchase card transactions properly. During the period September 1, 2004, through August 31, 2005, cardholders processed 23,152 transactions totaling about $13 million. While cardholders generally met VHA requirements for reconciling completed transactions, some transactions were not reconciled properly, which resulted in the transactions not being approved within 14 days, as required by VHA policy. Our review found 159 transactions totaling about $183,000 that cardholders had not properly processed. As a result, the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system had not alerted approving officials that these transactions needed approval.

At our request, the Purchase Card Coordinator initiated a review and identified 344 additional transactions totaling about $410,000 from FYs 2003 and 2004 that also had not been approved.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires medical center staff to: (a) develop processes and procedures for systematically monitoring unapproved transactions and follow up with cardholders and approving officials to ensure that unapproved transactions are for official purposes and (b) provide training to cardholders on the proper method of reconciling transactions.

The VISN 6 Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the identified transactions have been reviewed and status changed as appropriate; Fileman routines are run monthly to identify transactions that have not been approved, and the transactions are being reviewed and appropriate actions are being taken; and cardholders were trained on the proper method of reconciling transactions. We will follow up on the planned actions until they are completed.

[1] The "ABC System" determines the level of stock that will be stored based on cost and usage.

Other Observation

All Employee Survey

The medical center exceeded the requirements of Executive Career Field (ECF) performance measures in utilizing All Employee Survey (AES) data to change perceptions and improve employee satisfaction. VHA administers an AES every 3 years to assess employee and organizational satisfaction. An ECF performance plan measure required VISN directors to analyze the employee survey results and develop an action plan to address areas in need of improvement by September 30, 2004.

The medical center employee response rate was 60.3 percent – 7.7 percentage points higher than the average of the response rates for the other VISN 6 facilities. Shortly after VHA made the AES results available, the medical center formed a Steering Committee to lead the effort to change employee perceptions on key issues identified by the AES. The medical center assigned a data analyst to extract and analyze AES data. Although no factors of statistical significance fell below the VISN or national means, the Steering Committee chartered five process action teams (PATs) to target lower satisfaction areas including working conditions, conflict resolution, cooperation, and senior management. The PATs will report their findings and recommendations to the Steering Committee for consideration. Medical center management has planned a second series of town hall meetings to brief employees on selected initiatives.

Appendix A

VISN 6 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 8, 2005

From: Director, Veterans Integrated Service Network 6 (10N6)

Subject: **VA Medical Center Asheville, North Carolina**

To: James R. Hudson, Director, Atlanta Audit Operations Division (52AT)

1. The attached report with noted recommendations and corrective actions has been reviewed and is forwarded as requested.

2. If you have any questions, please contact Mr. Christian, Director, VA Asheville Medical Center directly at (828) 299-5999.

Daniel F. Hoffmann, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 2, 2005

From: Director, VA Medical Center Asheville, North Carolina (637/00)

Subject: **VA Medical Center Asheville, North Carolina**

To: James R. Hudson, Director, Atlanta Audit Operations Division

Thru: Mid-Atlantic Network Director (10N6)

1. The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report.

2. If you have any questions, please contact me at (828) 299-5999.

(original signed by:)

James A. Christian, FACHE

Medical Center Director's Comments to Office of Inspector General's Report

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

OIG Recommendation(s)

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director bring all beds into compliance with the Patient Safety Alert.

Concur **Target Completion Date:** 02/28/06

To comply with the 2001 VA Patient Safety Alert on Bed Rail Entrapment, Asheville VAMC has taken the following actions:

- All non-compliant beds have been permanently and clearly identified. Completed 10/06/05.
- Nurse Managers certified that all patients were assessed for risk of entrapment using VA National Center for Patient Safety assessment tool. Completed 10/11/05.
- Nurse Managers completed just-in-time training at change-of shift report -10/11/05.
- Hill-Rom contacted to arrange 100 percent bed safety assessment and provide quotes for repair vs. replacement - 10/12/05.
- NCPS Bed Entrapment Risk Assessment added to CPRS Nursing Admission Assessment Template and Nursing Reassessment Template - live in CPRS on 10/25/05.
- Results of Hill-Rom bed safety assessment with repair quotes received on 11/22/05.
- Bed replacement plan sent to VISN. Conference call with VISN Supply officer regarding bed replacement plan completed 12/02/05. Verbal commitment to a phased plan to be confirmed with VISN Director by

12/08/05 following submission from Asheville of the projected plan and fiscal requirements. Upon approval, immediate actions will be undertaken to purchase the needed beds. It is anticipated it will take approximately 90 days for this process to be completed.

- Unoccupied compliant Stryker beds from ECRC to be moved to ward 3East, making all beds compliant. Estimated completion date – 12/12/05. Excess compliant beds to be distributed to other wards, replacing non-compliant beds.
- Eliminate bed rail entrapment risk assessment from CPRS templates within two weeks after all beds meet guidelines.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires Environmental Management Service staff to maintain cleanliness in all bathrooms.

Concur **Target Completion Date:** Completed

The caulking around the sinks and toilets cited during the inspection was removed the day after it was cited. In addition, the housekeeping aide supervisors have specifically added a line item on the inspection checklists for discoloration around sink and toilet caulk-joints. The supervisors use the checklist during their daily and weekly inspections and with the ward supervisors during the monthly inspections.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) GIP records contain accurate inventory balances, (b) ICP stock usage is entered into GIP timely, (c) missing bar code labels are replaced, and (d) GIP records contain accurate nomenclature and units of issue information.

Concur **Target Completion Date:** 06/01/06

- Logistics Officer, responsible for oversight of inventory control; is hired and will report for duty by 01/31/06.
- Changing units of issue is in process and will be completed by 01/31/06.
- Fixing bar code labels is in process and will be completed by 01/31/06.
- Supply will scan all items into GIP to update issue quantities with completion date of 06/01/06.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires Pharmacy Service to: (a) develop an effective method for establishing inventory levels based on stock usage, and (b) reduce inventory levels.

Concur **Target Completion Date:** 01/31/06

Phase I – will implement a plan with purchasing to increase order schedule from weekly to twice weekly for certain controlled substances. Target Completion date: 12/31/05.

Phase II – in conjunction with Prime Vendor (McKesson) implement inventory management based on the ABC system. Target Completion date: 01/31/06.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires medical center staff to: (a) develop processes and procedures for systematically monitoring unapproved transactions and follow up with cardholders and approving officials to ensure that unapproved transactions are for official purposes, and (b) provide training to cardholders on the proper method of reconciling transactions.

Concur **Target Completion Date:** Completed

Transactions identified during the visit have been reviewed and status changes have been accomplished for appropriate related purchases. Fileman routines are being run on a monthly basis to identify, review, and take appropriate action for transactions not referred for approval. Training of all cardholders on proper method of transaction reconciliation was completed by 12/01/05.

OIG Contact and Staff Acknowledgments

OIG Contact	James R. Hudson, Director, Atlanta Audit Operations Division (404) 929-5921
Acknowledgments	Floyd C. Dembo, Audit Manager (CAP Review Coordinator) Willie J. Toomer, Audit Manager (Acting CAP Review Coordinator) Christa Sisterhen, Deputy Director, Atlanta Office of Healthcare Inspections George Patton, Audit Team Leader Susan Zarter, Healthcare Inspections Team Leader Ann Batson Leon Roberts Steve Wiggins Toni Woodard

Appendix D

Report Distribution

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