Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the James H. Quillen VA Medical Center Mountain Home, Tennessee

Report No. 06-02301-210 **September 13, 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 services are 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 August 14, 2006, the Office of the Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James H. Quillen VA Medical Center (the medical center), Mountain Home, TN. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 231 employees. In addition, we followed up on selected recommendations from the previous CAP review of the medical center.

Results of Review

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

- Community Nursing Home (CNH) Program
- Diabetes and Atypical Psychotropic Medications
- Breast Cancer Management
- Patient Satisfaction

We identified conditions in Biomedical Preventive Maintenance (PM), Environment of Care (EOC), and QM that needed management attention. The following recommendations were made:

- Complete and appropriately document scheduled PM inspections on all biomedical equipment.
- Ensure defibrillator test strips reflect accurate date and time stamps.
- Place an Automated External Defibrillator (AED) in the Eye Clinic.
- Ensure certification of Administrative Investigation Boards (AIBs).

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 11–14, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The James H. Quillen VA Medical Center is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community-based outpatient clinics (CBOCs) located in Rogersville and Mountain City, TN, and in Norton and St. Charles, VA. The medical center is part of Veterans Integrated Service Network (VISN) 9 and has a veteran enrollment of 41,467 in a primary service area that includes 33 counties in 3 states.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 111 hospital beds, 120 nursing home beds, and 298 domiciliary beds.

Affiliations and Research. The medical center is affiliated with East Tennessee State University (ETSU) James H. Quillen College of Medicine and supports 78 medical resident positions in 5 training programs. The medical center supports an additional 15 training programs in specialty areas. In Fiscal Year (FY) 2005, the medical center research program had 69 projects and a budget of $1.35 million. Important areas of research include Cardiology and Audiology.

Resources. In FY 2005, medical care expenditures totaled $180.5 million. The FY 2006 estimated medical care budget is $181.4 million. FY 2005 staffing totaled 1,323 full-time equivalent employees (FTE), including 103 physician and 230 nursing FTE.

Workload. In FY 2005, the medical center served 34,413 unique veterans. The medical center provided 28,998 inpatient days of care, 1,905 observation days of care, and 35,628 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 5,061 discharges, with an average daily census of 79 in the hospital, 98 in the NHCU, and 261 in the domiciliary. The outpatient workload was 330,482 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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facilities focusing on patient care and QM.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for 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 QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review (*Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, Report No. 01-00223-136, July 16, 2002.)*

In performing the review, we inspected work areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered selected aspects of the following programs and activities:

Biomedical Preventive Maintenance	Breast Cancer Management
Community Nursing Home Program	Environment of Care
Diabetes and Atypical Psychotropic Medications	Patient Satisfaction
	Quality Management

The review covered medical center operations for FY 2005 and FY 2006 through August 18, 2006, and was completed in accordance with OIG standard operating procedures for CAP reviews.

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.

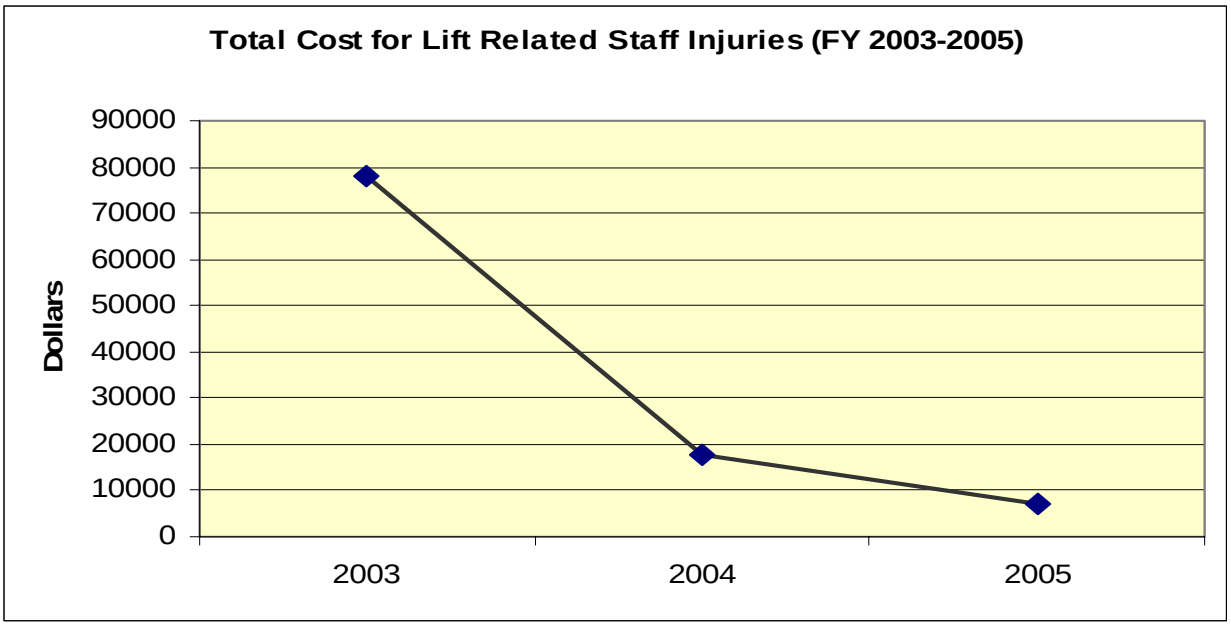
Results of Review

Organizational Strength

No-Lift Program for Safe Patient Handling Reduced Staff Injuries

The implementation of the No-Lift Program for Safe Patient Handling (use of equipment versus manual lifting and transferring of patients) has improved staff safety and has reduced costs associated with lift-related injuries. The No-Lift Program for Safe Patient Handling promotes the use of ceiling-mounted mechanical lifts and lateral transfer devices and includes a policy outlining the requirements of the program, educational components to assure staff competency and awareness, a patient and family educational brochure, and equipment.

In FY 2003, injury data identified 34 Nursing Service staff injuries associated with patient handling, and 17 of those injuries occurred on the NHCU. The direct costs (medical expenses and lost time) totaled $77,813, with an average of $2,289 per injury. Medical center managers approved a pilot program and provided funding for equipment purchase for the NHCU. The pilot program resulted in reduced staff injuries and costs, and was implemented in additional locations throughout the medical center. Evaluation of the FY 2005 data showed that while there were 27 injuries related to patient handling, direct costs had substantially declined to $7,039, at an average of $261 per injury. The following graph illustrates the comparisons of FY 2003 through FY 2005:



The No-Lift Program is now being implemented at medical centers across VISN 9.

Opportunities for Improvement

Biomedical Equipment – Preventive Maintenance Was Improperly Deferred

The medical center did not complete PM as scheduled on critical patient care equipment. The Biomedical division of Engineering Service repairs and maintains biomedical equipment, such as defibrillators, ventilators, and infusion pumps. The manufacturers of biomedical equipment recommend PM inspections (monthly, quarterly, semi-annually, or annually) to ensure that equipment is functioning properly for patient use.

PM inspections are required by Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Standard EC[1] 6.10.4 requires that the hospital identify appropriate inspection and maintenance strategies for all equipment in the inventory for achieving effective, safe, and reliable operation. Standard EC 6.10.5 requires that, "The hospital identifies intervals for inspecting, testing and maintaining appropriate equipment on the inventory that are based upon criteria such as manufacturers' recommendations, risk levels, and current hospital experience."

Condition Needing Improvement. During our tour of the medical center, we randomly selected 12 pieces of biomedical equipment that were either in use or located in patient care areas. The PM logs on three of these items did not reflect timely PM. In two cases, defibrillators that should have received PM in August 2005 did not get this service until February of 2006. Engineering Service managers told us that PM was deferred on all biomedical equipment scheduled for August 2005 so that Biomedical division staff could assist with the Operating Room (OR) and Surgery relocation. A memorandum from the Chief of Engineering Service to the Chairman of the Executive Safety Committee dated September 14, 2005, states, "Preventive Maintenance was deferred during the OR move. All items deferred will be inspected during their next PM cycle." As a result, approximately 139 items did not receive the recommended PM. Depending on the timing of PM, this plan resulted in some medical equipment not being inspected by Biomedical staff for almost 2 years. While the decision to defer PM was not pre-approved by medical center management, the Executive Safety Committee also did not take action after receiving the memo about deferred PM. We did not identify any negative impact on patient care as a result of deferred PM, and by the end of August 2006, all PM deferred in August 2005 will have been completed.

In addition, the maintenance log for the third piece of equipment, an infusion pump, listed the last annual PM inspection in January 2005. The Chief of the Biomedical division told us that all PM conducted in January 2006 did not register on the maintenance logs. It was unclear how this error occurred, or whether the data was

[1] Standard EC is JCAHO's environment of care standard.

retrievable. The Chief was able to produce workload reports for the 2nd quarters of 2005 and 2006 reflecting similar inspection statistics, which suggests that the January 2006 PM was completed.

PM is a critical function that minimizes the potential for equipment malfunctions and adverse patient outcomes. When PM inspections do not occur as scheduled, patient care and safety is compromised.

Recommended Improvement Action(s) 1. The VISN Director needs to ensure that the Medical Center Director requires PM inspections be completed as scheduled on all biomedical equipment in inventory and that those inspections are appropriately documented.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that the patient care equipment management policy has been amended to prohibit exceptions to PM schedule requirements, and includes a new system to document completed PM. The Executive Safety Committee minutes will document completion of all scheduled PM. We will follow up on the planned actions until they are completed.

Environment of Care – Patient Safety Deficiencies Should Be Corrected

The purpose of the evaluation was to determine whether the medical center established a comprehensive EOC program that met selected Veterans Health Administration (VHA), Occupational Safety and Health Administration (OSHA), and JCAHO standards. To evaluate EOC, we inspected six areas (clinical and non-clinical) of the medical center for cleanliness, safety, infection control, and general maintenance. Overall, we found the medical center to be clean and well-maintained. Managers provided excellent documentation of EOC rounds and timely abatement of identified conditions. Nurse managers reported that housekeeping staff assigned to their units were conscientious and responsive. However, we identified the following patient safety deficiencies requiring management attention.

Conditions Needing Improvement. There was no defibrillator or AED in the Eye Clinic in Building 8. VHA policy states that AEDs should be considered for locations where there is "a reasonable probability of one AED use in 5 years." A review of cardiac arrest events from FY 2001 through FY 2006 revealed one code blue event in the Eye Clinic during that time frame. Without an AED in the area, patients receiving care in the Eye Clinic do not have the same access to an AED as those receiving care in other areas of the medical center.

We also found that printed defibrillator strips in two areas reviewed recorded the wrong dates, and in one case, the wrong time. In the NHCU, the printed defibrillator strip

recorded the test date as August 9, 1986, at 00:01:34 (12:01 a.m.). The correct test date was August 15, 2006, at approximately 1:15 p.m. In the Intensive Care Unit (ICU), the strip recorded the date as August 16, 2006, which was one day in the future. Accurate time-stamping is important as it allows clinicians to assess and correlate patient events. In addition, incorrectly dated and/or timed paper recordings printed during an actual cardiac code could be a liability should the medical center have to defend itself in legal proceedings.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that: (a) an AED is placed in the Eye Clinic and (b) defibrillator test strips reflect an accurate date and time stamp.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported placement of an AED in the Eye Clinic. In addition, medical center staff verified the accuracy of each defibrillator's date and time stamp and made corrections as needed. In the future, daily monitors, annual maintenance checks, and Administrative Environment of Care rounds will include monitoring of the accuracy of the date and time stamp. We will follow up on the planned actions until they are completed.

Quality Management – Certification of AIBs Needed Improvement

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 and appropriately responded to QM efforts; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. The QM review included a self-assessment of the QM program completed by the quality manager and interviews with senior management staff. We found that overall QM staff were supported by senior managers in effectively monitoring patient care activities. However, we identified a deficiency related to AIBs.

Conditions Needing Improvement. In our review of all AIBs conducted during FY 2005 and FY 2006, we found that only one of four included the convening authority (medical center director) certificate of completion. VHA Handbook 0700, *Administrative Investigations*, requires the medical center director to certify proper investigation and completion of the AIB in accordance with VHA requirements. The certificate of completion includes an opportunity for the medical center director to modify or comment on the findings of the AIB report, as well as note corrective action taken. The certificate of completion certifies that the accuracy and completeness of the AIB has been verified.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director certifies completion on all AIBs.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that all future AIBs will include a certification of completion template. The template will be filed with the AIBs, and will be tracked by QM. We will follow up on the planned action until completed.

Other Focused Review Results

Community Nursing Home Program – Oversight Was Comprehensive

CNH Program staff provided appropriate and comprehensive oversight of the community nursing facilities caring for veterans. We reviewed the CNH Program to assess compliance with local and national policies regarding the selection of contract facilities, the review process for contract renewal, and the monitoring of patients in community nursing facilities. We evaluated whether patients received rehabilitation services (speech, physical, or occupational therapy) when ordered and whether there were effective processes in place to more closely monitor the community nursing facilities where deficiencies had been identified.

The medical center currently has 60 veterans under contract in 24 community nursing facilities located in Tennessee and Virginia. We selected five community nursing facilities for review and visited two of them. We interviewed the administrators at these sites, toured the facilities, and visited the veterans under contract there. We conducted 10 patient record reviews and interviewed 3 patients and 4 family members.

The CNH review team utilized the exclusion report (which summarizes quality indicators and results of state and other inspections) to complete their annual review of each facility. Contract renewal recommendations were based on these reviews. We found that CNH Program staff recommended increased monitoring, suspension of placements, or contract termination when appropriate.

Families and community nursing facility staff told us, and we confirmed by medical record review, that a CNH Program nurse or the CNH Program social worker visited at least monthly. We found documentation of these visits in the patients' VA medical records, and visit notes contained evidence of patient assessment and discussion of concerns with the facility staff or administrator when indicated. The administrators, nursing directors, patients, and family members told us that CNH Program staff were accessible and responsive to their needs and concerns. We also confirmed that patients received contracted services, as ordered.

We found evidence that CNH Program staff collected and reviewed Performance Improvement (PI) data from the community nursing facilities and that they conducted their own PI monitors. One of their PI efforts resulted in a change in the billing process for patients receiving rehabilitation in the community nursing facilities. Previously, the VA paid the rehabilitation rate instead of the basic rate for the duration of the treatment

period. The medical center saved up to $9,000 a month by paying the higher rehabilitation rates only on the days patients actually received therapy services.

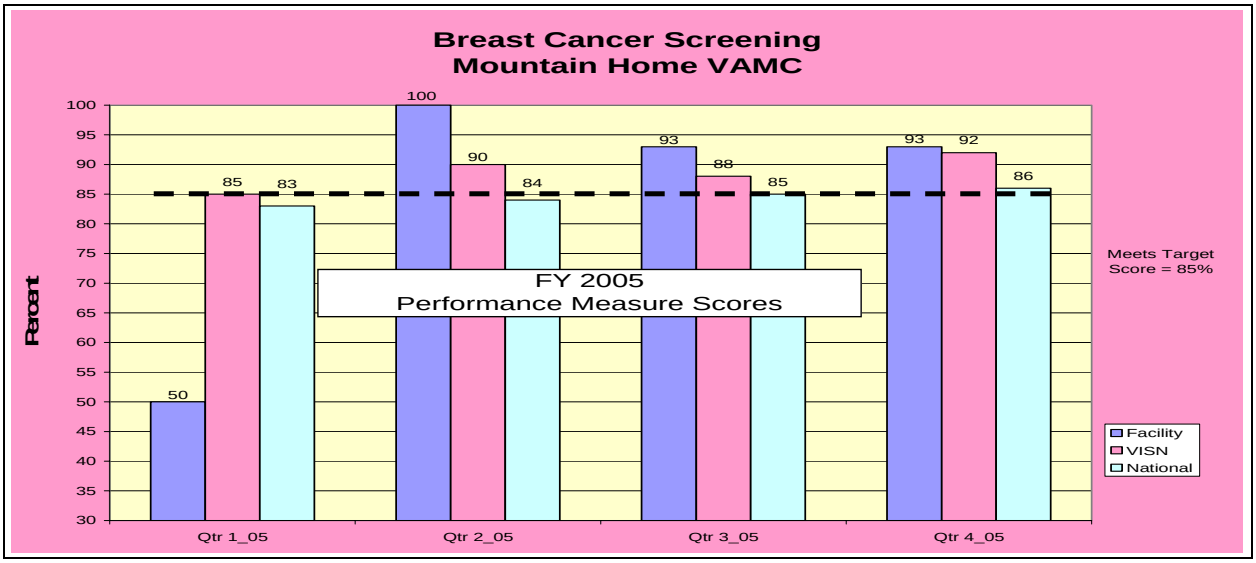
Diabetes and Atypical Psychotropic Medications – Monitoring and Treatment Were Appropriate

We reviewed the medical records of 13 mental health patients receiving atypical psychotropic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes) who were on these medications for at least 90 days in FY 2005. We evaluated the effectiveness of diabetes screening, monitoring, and treatment by reviewing the hemoglobin A1c (HbA1c reflects the average blood glucose level over a period of time), the blood pressure, and the cholesterol level of diabetic mental health patients receiving these medications.

We found that medical center clinicians performed effective monitoring and treatment of the two diabetic patients in our sample. The 11 non-diabetic patients were appropriately screened for diabetes, and counseled about diabetes prevention.

Breast Cancer Management Was Appropriate

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Managers told us and documentation confirmed that they did not meet the target in the 1st quarter of FY 2005 because women veterans who refused screening were included in the denominator for the calculation. The medical center achieved the fully satisfactory level in the 2nd through the 4th quarters. The following table illustrates the medical center's breast cancer screening performance.



Timely diagnosis, notification, and interdisciplinary treatment planning are essential to optimal patient care. We reviewed these items for the one patient diagnosed with breast

cancer in FY 2005. The patient had appropriate screening and received a timely biopsy and treatment. Clinician-patient communication and patient involvement in the treatment planning process were adequate. We found good coordination of care from the time of presentation for screening to the conclusion of treatment.

Patient Satisfaction – Managers Were Addressing Deficiencies

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 analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. The following graphs show the medical center's (or clinics's) performance in relation to national and VISN performance. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as very good or excellent. Medical centers are expected to address areas in which they are underperforming.

Mountain Home Outpatient SHEP Results

Q1 and Q2 FY06

Facility Name	Facility Numbers	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National		**80.7**	**78.1**	**94.8**	**72.6**	**83.3**	**75.8**	**81.5**	**65.5**	**81.7**	**80.8**	**84.7**
VISN 9 - Overall		**80.5**	**78.4**	**94.7**	**70.8**	**83**	**76**	**81.4**	**70.8**	**80.6**	**82.7**	**84.8**
MOUNTAIN HOME OPC-Overall		80.6	88	95.2	70.3	87	76.6	84.1	68	80.7	86.7	79.3
_ MOUNTAIN HOME OPC	621	80.4	88.8	95.2	69.8	86.9	76.2	84.2	67.6	80.4	86.9	78.6
_ ROGERSVILLE OPC	621GA	79.9	68.7	94.9	70.2	82.1	72.2	80.4	*	82	*	90.4
_ MOUNTAIN CITY OPC	621GB	85	67.8	97.3	74.9	83.2	81.1	83	*	84.5	*	87.1
_ NORTON OPC	621GC	83.3	65	95.9	80.3	87	81.7	83	*	84.5	*	91.2
_ ST. CHARLES CBOC	621GD	84.1	75.5	93.4	79.8	87.1	82.3	83.2	*	85.9	*	94.2

** Less than 30 respondents*

Mountain Home Inpatient SHEP Results

Q2 FY06

Facility Name	Facility No.	Bed section	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	**National**	**All Bed Sections**	**81.31**	**78.63**	**89.95**	**68.02**	**65.80**	**75.85**	**83.41**	**74.49**	**70.03**	******
VISN 9	Overall	ALL	82.3	78.50	90.6	69.6	68.2	74.9	83.40	76.4	70.90	**
Mountain Home VA	621	ALL	84	79.50	92.2	72.3	72.3	73.90	84.00	79.6	75.3	**

*** Less than 30 respondents*

The medical center had a designated SHEP Coordinator who analyzed SHEP results and reported this data to top management. Action plans were developed for those areas needing improvement; for example, several CBOCs showed substandard performance in continuity of care and education/information. Medical center managers took action to renegotiate the CBOC contracts to reflect performance requirements. Corrective actions were adequately tracked and followed to closure.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 6, 2006

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

Subject: **Draft Report -** Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, TN - Report Number 2006-02301-HI-0366

To: Assistant Inspector General, Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. Attached please find the response to recommendations noted in the most recent Office of the Inspector General (OIG), Combined Assessment Program (CAP) Review of the James H. Quillen, Department of Veterans Affairs Medical Center, Mountain Home, Tennessee conducted August 14-18, 2006.

2. I concur with the Medical Center Director's comments and action plan.

3. If you have any questions or need additional information, please contact Charlene Ehret, Medical Center Director, James H. Quillen VAMC at (423) 979-3590; Lori Hagen, Chief of Quality Management and Improvement, James H. Quillen VAMC at (423) 979-3617; or Donna Savoy, Staff Assistant to the Network Director, VISN 9 at (615) 695-2205.

(original signed by:)

John Dandridge, Jr.

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2006

From: Director, James H. Quillen VA Medical Center (621/00)

Subject: **Draft Report -** Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, TN - Report Number 2006-02301-HI-0366

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

1. Attached please find VAMC Mountain Home's response to the Office of Inspector General (OIG), Combined Assessment Program (CAP) conducted August 14-18, 2006.

2. If you have any questions regarding this information provided, please contact Lori Hagen, Chief of Quality Management and Improvement at (423) 979-3617.

(original signed by:)
T. J. O'Neil acting for/

CHARLENE S. EHRET, FACHE

Attachment

Director's 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 Recommendation(s)

Recommendation 1. The VISN Director needs to ensure that the Medical Center Director requires PM inspections be completed, as scheduled, on all biomedical equipment in inventory, and that those inspections are appropriately documented.

Concur Target Completion Date: August 31, 2006

The medical center policy for patient care equipment management has been amended to prohibit any exceptions to the requirement for preventative maintenance (PM) as recommended by the equipment manufacturer, i.e., monthly, quarterly, semiannually or annually. The equipment management report to the Executive Safety Committee will be used as verification that PMs have been completed when scheduled. Additionally the policy is amended to include a requirement for self adhering labels to be affixed to equipment by the inspecting technician, at the time of inspection, annotated with the equipment inventory number, date of inspection, and the technician's initials.

Recommendation 2. The VISN Director should ensure that the Medical Center Director requires that:

a. An AED is placed in the Eye Clinic.

b. Defibrillator test strips reflect an accurate date and time stamp.

Concur Target Completion Date: September 30, 2006

a. An AED was placed in the Eye Clinic on August 18, 2006.

b. Each defibrillator was checked for an accurate date and time stamp with appropriate action taken if they were not accurate. The verification of defibrillator test strip date stamp accuracy will be included in the daily defibrillator user testing. The Biomedical Engineering staff will include this verification of accurate time and date during the annual preventative maintenance checks. The Administrative Environment of Care team will also include this verification during their weekly rounds and defibrillators which are not accurate will be placed on the report for action.

Recommendation 3. The VISN Director should ensure that the Medical Center Director certifies completion on all AIBs.

Concur Target Completion Date: August 31, 2006

The Risk Manager created an Administrative Investigation Board (AIB) template for use on all AIBS for the certification by the convening authority to complete. This certification of completion includes the opportunity for the convening authority to modify or comment on the findings of the AIB report, as well as corrective actions taken. This certification of completion will be tracked and filed with each AIB file in Quality Management.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Toni Woodard, Healthcare Inspections Team Leader David Carson Victoria Coates Michael Keen Susan Zarter

Appendix D

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