Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02721-47

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

December 22, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
ED	emergency department
EN	enteral nutrition
EOC	environment of care
facility	Charles George VA Medical Center
FY	fiscal year
IC	infection control
MH	mental health
MWV	management of workplace violence
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
SA RRTP	Substance Abuse Residential Rehabilitation Treatment Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VLER	Virtual Lifetime Electronic Record

Table of Contents

Executive Summary: Combined Assessment Program Review of the Charles George VA Medical Center, Asheville, NC

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 26, 2011.

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

- Enteral Nutrition Safety
- Medication Management
- Physician Credentialing and Privileging
- Registered Nurse Competencies

The facility's reported accomplishment was successfully implementing the Virtual Lifetime Electronic Record program.

Recommendations: We made recommendations in the following four activities:

Quality Management and Leadership Oversight: Conduct an overall evaluation and redesign of the committee reporting structure. Comply with requirements for data trending and analysis. Require all monitoring and evaluation activities to include result reporting and action tracking. Comply with requirements for utilization management and resuscitation.

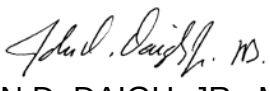
Environment of Care: Document discussion of identified deficiencies and actions taken in committee minutes. Complete and monitor compliance with bloodborne pathogens training. Complete area-specific inspections. Comply with mental health environment of care requirements. Ensure Substance Abuse Residential Rehabilitation Treatment Program inspections include documentation of compliance with privacy requirements.

Coordination of Care: Follow up with patients interested in additional advance directive information. Attempt to secure existing advance directives. Provide patients with copies of advance directives. Update policy to include training for staff who notify, screen, and assist with advance directives.

Management of Workplace Violence: Appoint a management of workplace violence coordinator. Complete annual vulnerability assessments, trend data, and develop strategies to reduce risks. Develop and implement a training plan for all staff.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.



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

Objectives and Scope

Objectives

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

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

Scope

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Medication Management
- MWV
- Physician C&P
- QM and Leadership Oversight
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 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 facility (*Combined Assessment Program Review of the Charles George VA Medical Center, Asheville,*

North Carolina, Report No. 08-03075-137, June 2, 2009). The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 754 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.

Reported Accomplishment

VLER Program

The facility was successful in enrolling veterans in the VLER pilot program. The VLER program shares portions of veterans' health records among VHA, the Department of Defense, and selected private health care providers over a secure computer network. Sharing of veterans' health records helps reduce the need to carry hard-copy health records between health care providers. In addition, the availability of all medical information allows providers to make informed decisions, minimizes duplication of efforts (laboratory tests, medications, imaging), and promotes safe patient care. The facility reported that since the pilot began in April 2011, more than 900 veterans (approximately 10 percent of the catchment area) have enrolled in VLER and have authorized the sharing of their health care information.

Results

Review Activities With Recommendations

QM and Leadership Oversight

The purpose of this review was to evaluate whether the facility operated in a manner that provided veterans with consistent, safe, high-quality health care in accordance with VHA policies.

We interviewed senior managers, QM personnel, and committee chairpersons; toured the facility; and evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Overall QM and Oversight Structure. VHA requires an organized, systematic approach to measure, improve, and

monitor overall QM activities and oversight to ensure that QM components are implemented and integrated.[1] The QM program did not provide the necessary monitoring and oversight to assure that patient care processes were safe and effective.

While we did not identify any actual cases of patient harm or adverse events in the areas we reviewed, we found systemic deficiencies in QM and other program areas that increased the possibility of negative outcomes. We found multiple instances where the facility was not compliant with long-standing VHA guidance as well as cases where the facility appropriately identified some of its own weaknesses but did not correct the problems.

The facility's committee oversight structure was not fully integrated or functional, and accountability for quality monitoring and performance improvement activities appeared limited. Opportunities for improvement generally fell into one of four categories as defined by VHA policy or external accrediting body standards. The categories are listed in the first column of the table below.

QM is typically not responsible for the EOC or IC Committees and does not oversee their functions; however, we included EOC and IC to illustrate the extent to which the deficiencies spanned multiple program areas. (See pages 5–7 for additional EOC- and IC-related information.)

Table A. Oversight Committee Requirements

	Committee Reviewed					
MINUTES REFLECTED INCOMPLETE OR INADEQUATE:	EOC	IC	Medical Records	Peer Review	Resuscitation and Its Outcomes	System Redesign/ Patient Flow
Reporting – not all required elements present	**X**	**X**		**X**	**X**	
Data trending and analysis	**X**	**X**	**X**	**X**	**X**	
Documentation of conclusions, recommendations, and corrective action completion	**X**	**X**	**X**	**X**	**X**	**X**
Reporting to and/or evaluation by an oversight committee	**X**	**X**	**X**	**X**	**X**	

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

When the processes and monitors shown in the first column of the table are functioning effectively, they should identify and correct potential and actual deficiencies *before* quality of care and patient safety are compromised.

A functional oversight structure assures that oversight committees and their subordinate committees consistently comply with reporting guidelines and appropriately implement and follow up on recommendations and corrective actions. When oversight committees receive inadequate information, they are expected to question the lack of data and require the subordinate committee to explain the deficiency.

Facility managers could not rely on internal monitoring and oversight processes to detect and correct potentially problematic areas. These deficiencies had the potential to hinder senior managers' abilities to make reasonable, data-driven decisions and address opportunities for improvement.

Compliance With Policies. VHA requires referral of cases to a physician utilization management advisor for review when admission or continued stay criteria are not met, but local policy can allow the facility to identify situations when referral to the advisor is not needed.[2] However, the policy identifying these exemptions was dated August 23, 2011. Prior to that date, the facility did not forward all cases to the physician utilization management advisor.

VHA requires that local policy define the membership and responsibility of a Cardiopulmonary Resuscitation Committee; however, the facility did not have the required policy.[3] The facility had a subcommittee of the Critical Care Committee that reviewed some code-related issues, but their activities did not fully meet VHA requirements.

After our review, we discussed our concerns with the VISN Director.

Recommendations

1. We recommended that facility managers conduct an overall evaluation and redesign, as needed, of the committee reporting structure.

[2] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committee*, October 17, 2008.

2. We recommended that QM and other facility and program leaders comply with VHA requirements for data trending and analysis.

3. We recommended that all monitoring and evaluation activities include proper reporting of results and tracking of actions to ensure identification of improvement opportunities and correction of deficiencies.

4. We recommended that processes be strengthened to ensure compliance with VHA requirements for utilization management and resuscitation.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's SA RRTP complied with selected MH Residential Rehabilitation Treatment Program requirements. We also determined whether issues identified in EOC and IC Committee minutes were tracked and followed up until resolved.

We inspected the ED; the medical specialty, dental, pre-operative, and primary care clinics; the medical and surgical intensive care units; the interventional radiology and endoscopy suites; the inpatient medicine, oncology, surgical, and MH units; same day surgery; the community living center; and the SA RRTP. The facility maintained a generally clean environment. However, we identified the following conditions that needed improvement.

Deficiency Identification and Tracking. VHA requires facility-wide occupational safety and health management issues to be identified, tracked, and resolved in a timely manner.[4] In addition to those EOC- and IC-related deficiencies identified in the table on page 3, we found that safety-related reporting elements were sometimes deferred in EOC Committee meeting minutes but were not presented at the next meeting. Additionally, EOC-related patient safety alerts, advisories, and adverse events were not presented, and actions were not documented.

IC. The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule.

[4] VHA Handbook 7701.01, *Occupational Safety and Health (OSH) Program Procedures*, August 24, 2010.

We reviewed 33 employee training records and found that 13 employees (39 percent) did not have this training documented.

VA requires that medical inventory be verified on a regular basis for outdated, damaged, or obsolete items and that medical device expiration dates be checked to ensure products are safe for use.[5] The Joint Commission requires that hospitals remove all expired, damaged, and/or contaminated medications. Local policy requires that nourishment refrigerator temperatures be checked daily to ensure food product safety.

During our tour of the facility, we found the following:

- Expired sterile instrument trays (ED, operating room)
- Expired supplies in a physician's office (ED)
- Expired and unsecured medications (ED, pre-operative clinic)
- Expired nitroglycerin intravenous solution (interventional radiology)
- Malfunctioning nourishment refrigerator thermometer (inpatient medical unit)

Environmental Safety. VHA requires use of the MH EOC Checklist, which was designed to help clinicians identify and address environmental risks for inpatient suicide and suicide attempts.[6] MH inpatient environments are evolving to align with MH safe-design guidelines issued by the American Institute of Architects, The Joint Commission, the National Association of Psychiatric Health Systems, and VA[7] to eliminate and mitigate environmental conditions that could pose safety risks to patients. During our tour of the inpatient MH unit, we found the following:

- Removable desk drawers in patient rooms
- Standard office furniture in patient dining, day, and sleeping rooms (on abatement plan since 2008)
- Movable platform beds (on abatement plan since 2008)
- A restraint bed with a sheet, pillow, and blanket
- Mechanical beds located in unsecured patient rooms distant from the nurses' station

[5] VA Handbook 7176, *Supply, Processing, and Distribution (SPD) Operational Requirements,* August 16, 2002.
[6] VHA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC),* September 22, 2011.
[7] VA Office of Construction and Facilities Management, *Design Guide – Mental Health Facilities,* December 2010.

- A seclusion room mattress with a zippered, non-breathable mattress cover
- An unsecured fire equipment closet in a common hallway containing an unsecured fire extinguisher
- An unsecured and unattended housekeeping cart containing plastic bags and brooms and mops with wooden and metal handles

SA RRTP Privacy Inspections. VHA requires facilities to conduct and document monthly SA RRTP self-inspections that include safety, security, and privacy.[8] Although self-inspections were completed for the past 6 months, documentation of the inspections did not include reviews of compliance with privacy requirements.

Recommendations

5. We recommended that processes be strengthened to ensure that EOC and IC Committee minutes document discussion of identified deficiencies and actions taken and include patient safety alerts, advisories, and adverse events.

6. We recommended that annual bloodborne pathogens training be completed and that compliance be monitored.

7. We recommended that area-specific EOC inspections be completed that include reviews of equipment, medications, and nourishment refrigerators and that corrective action plans for deficiencies be monitored until fully resolved.

8. We recommended that processes be strengthened to ensure compliance with MH EOC Checklist requirements and that corrective action plans for deficiencies be monitored until fully resolved.

9. We recommended that processes be strengthened to ensure that monthly SA RRTP self-inspections include documentation of compliance with privacy requirements.

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed 20 patients' medical records for evidence of advance directive notification and screening and documentation of advance care planning discussions. We

[8] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following areas that needed improvement.

Advance Directive Screening. VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an advance directive and document the screening in the medical record.[9] If the patient has an advance directive, the screener must ask for a copy of the document to file in the patient's record. If the patient does not have an advance directive, the patient must be asked whether he or she desires more information about advance directives or would like assistance in completing one. We found that:

- Four of the 10 patients who reported that they did not have advance directives were not asked whether they were interested in receiving more information.

- Three of the 10 patients who reported that they had advance directives also indicated that those documents were not on file at the facility. However, there was no documented evidence that staff asked for copies.

Management of Advance Directive Documents. VHA requires that staff members who assist with completing advance directives give a printed copy to the patient.[10] In two of the three cases where facility staff assisted with the advance directive, we found no documented evidence that the patients were provided with a copy of the document.

Facility Policy. VHA requires that the facility identify and train the staff responsible for conducting notification and screening and for providing patients assistance in completing advance directive forms.[11] Facility policy did not include a training component.

Recommendations

10. We recommended that processes be strengthened to ensure that staff follow up with patients who express an interest in additional advance directive information.

[9] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, July 2, 2009.
[10] VHA Handbook 1004.02.
[11] VHA Handbook 1004.02.

11. We recommended that processes be strengthened to ensure that staff make an effort to secure existing advance directives that are not on file at the facility.

12. We recommended that processes be strengthened to ensure that when facility staff assist patients with completing advance directives, the patients are provided with copies and the medical records are documented.

13. We recommended that facility policy be updated to include a training component for staff responsible for notification and screening and for providing assistance with completion of advance directive forms.

MWV

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following areas that needed improvement.

Program Coordination and Oversight. VHA requires facilities to designate an appropriate official to coordinate the MWV program.[12] Local policy defines responsibility for various reporting and oversight aspects of the program.

We found that local policy designated two officials to co-coordinate the MWV program; however, both employees acknowledged that they had not functioned as MWV co-coordinators. At the time of our review, a nurse had been presenting MWV at new employee orientation sessions and developing training modules; however, this nurse's role was not defined, and the nurse lacked authority to mandate training and oversee other program functions.

Compliance with Facility Policy. The Occupational Safety and Health Administration requires facilities to have a comprehensive written workplace violence policy. While the facility had a policy, responsible staff or designated committees did not comply with some required elements:

[12] Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.

- Completing annual vulnerability assessments to identify potential sources of violent behavior and to determine the units and individuals most likely to be at risk
- Trending data and developing strategies to reduce or eliminate risks

Training. VHA requires that all staff receive MWV training commensurate with the degree of risk associated with their roles, responsibilities, and job site.[13] The facility lacked a comprehensive training plan.

Recommendations

14. We recommended that the facility appoint one MWV coordinator and update local policy to reflect this change.

15. We recommended that the facility complete annual vulnerability assessments, trend data, and develop strategies to reduce or eliminate risks.

16. We recommended that the facility develop and implement a workplace violence training plan for all staff in accordance with VHA requirements.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared,

[13] VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities,* February 22, 2010.

transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies and operating procedures, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 17–25 for full test of the Directors' comments.) We consider Recommendation 14 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[14]		
Type of Organization	Tertiary	
Complexity Level	2	
VISN	6	
Community Based Outpatient Clinics	Franklin, NC Rutherfordton, NC	
Veteran Population in Catchment Area	99,150 (FY 2011)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	137	
• **Community Living Center/Nursing Home Care Unit**	120	
• **Other**	N/A	
Medical School Affiliation(s)	Duke University Medical Center	
• **Number of Residents**	14 slots, 9 matched	
	FY 2011 (through June 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$190.9	$239.1
• **Medical Care Expenditures**	$192.1	$238.7
Total Medical Care Full-Time Employee Equivalents	1,496	1,426
Workload:		
• **Number of Station Level Unique Patients**	31,947	32,383
• **Inpatient Days of Care:**		
o **Acute Care**	42,841	30,334
o **Community Living Center/Nursing Home Care Unit**	18,630	18,783
Hospital Discharges	3,893	4,899
Total Average Daily Census (including all bed types)	172	163.6
Cumulative Occupancy Rate (in percent)	67.1	68.1
Outpatient Visits	258,720	331,341

[14] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure staff comply with local policy on cardiopulmonary resuscitation training.	The Talent Management System generates electronic notification to employees and supervisors of pending expirations 30 and 60 days in advance. Increased class availability and supervisor follow-through sustains training requirement compliance.	N
2. Ensure privileges for contracted physicians do not exceed the contract period.	Current contracts expiring at the end of September 2011 coincide with the expiration of privileges. C&P now obtains contract dates from contracting and sets privilege effective to/from dates based on the contract dates.	N
EOC		
3. Require that pharmacy managers evaluate medication redistribution practices to ensure that medications are safe for patients.	Facility policy states that "only pharmacy personnel will perform the labeling of packaged medication with the exception of medications prepared for use within the sterile field. A tamper evident seal is placed on appropriate ward medications during the dispensing process." VHA policy directs reuse of inhalers under certain conditions. Nursing staff do not have the means to re-label or re-issue on clinical units.	N
Emergency/Urgent Care Operations		
4. Ensure staff document patients' informed consent for transfer and advanced directive status prior to transfer to another facility	The interfacility transfer note template has required fields to document informed consent and advance directives. The signed consent is scanned into the note, and compliance is tracked by the transfer coordinator.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Medication Management		
5. Ensure nurses document the effectiveness of pain medications within the timeframe established by local policy.	The Bar Code Medication Administration coordinator provides a weekly PRN (as needed) effectiveness summary to nurse managers for continued attention and action.	N

VHA Satisfaction Surveys

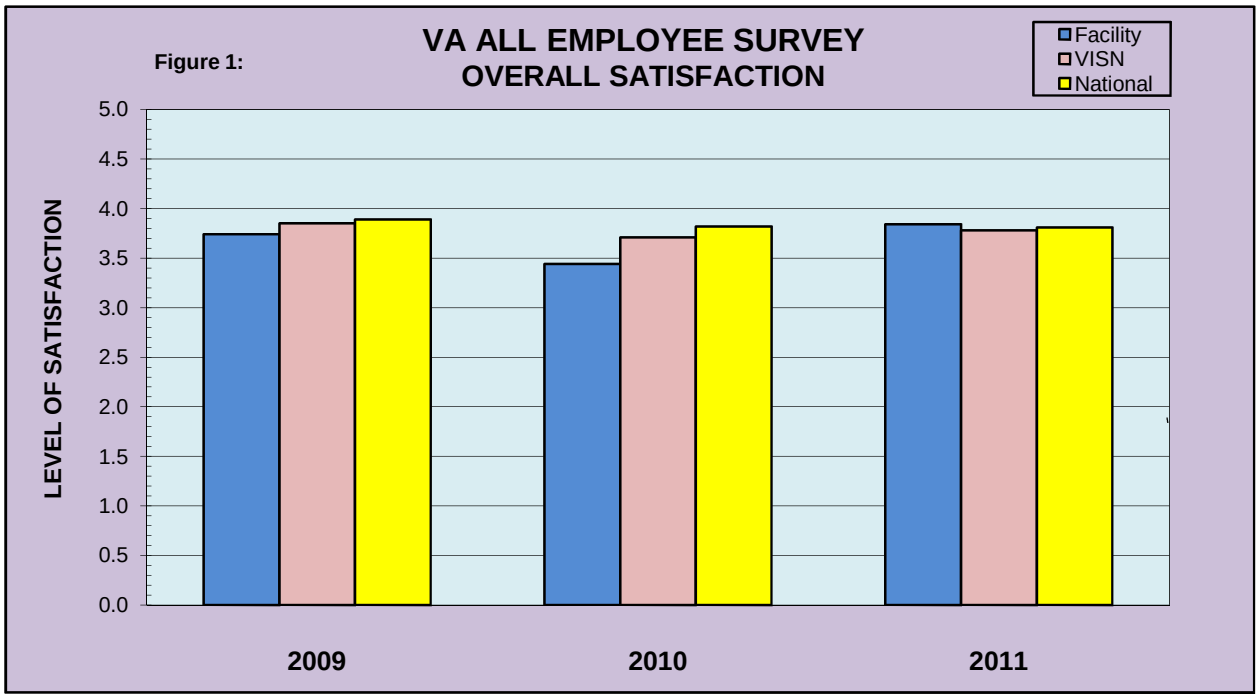
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	71.9	64.1	65.3	73.6	62.5	61.5
VISN	62.0	52.2	46.5	62.8	50.1	49.5
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[15] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[16]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	14.2	11.9	11.6	20.3	23.9	20.8
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[15] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[16] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 25, 2011

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

Subject: **CAP Review of the Charles George VA Medical Center, Asheville, NC**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. The attached subject report is forwarded for your review and further action. I reviewed the responses and concur with the facility's recommendations.

2. Please contact Cynthia Breyfogle, Director Charles George VA Medical Center, at 828-298-7911, ext. 5224, if you have further questions.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 25, 2011

From: Director, Charles George VA Medical Center (637/00)

Subject: **CAP Review of the Charles George VA Medical Center, Asheville, NC**

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

Charles George VA Medical Center concurs with these findings. We have provided the specific corrective actions we have taken and those that are still in process for each recommendation.

(original signed by:)
CYNTHIA BREYFOGLE, FACHE

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 facility managers conduct an overall evaluation and redesign, as needed, of the committee reporting structure.

Concur

Target date for completion: 01/27/12

Response: A workgroup chartered by the Executive Leadership Team (ELT) completed comparative analysis of Charles George Veterans Administration Medical Center (CGVAMC) Council and oversight structure against VHA and accrediting body requirements and other Medical Centers. A committee structure redesign will be approved by the Leadership Board as of 12/07/11 and implemented Medical Center wide by 01/27/12. A Medical Center Memorandum (MCM) regarding Board/Council/Committees Function for the Medical Center will be approved which will guide the redesign.

Recommendation 2. We recommended that QM and other facility and program leaders comply with VHA requirements for data trending and analysis.

Concur

Target date for completion: 03/30/12

Response: The process for ensuring that the Medical Center comply with VHA requirements for data trending and analysis includes: Committee Chairs reviewing their areas of oversight; individualized Committee Chair education on data trending and analysis; and audit teams comprised of Committee Chairs, Quality Management staff and recorders, meeting after Board/Council/Committees. Scheduled audits will begin in January 2012. The teams will audit the minutes to ensure completion of accurate minutes, analysis and trending of data that meet VHA requirements as well as perform just in time training. These audit results will be aggregated and the analysis of these audit data will be reported monthly to the Leadership Board through the Quality Executive Council (QEC).

Recommendation 3. We recommended that all monitoring and evaluation activities include proper reporting of results and tracking of actions to ensure identification of improvement opportunities and correction of deficiencies.

Concur

Target date for completion: 01/27/12

Response: A leadership workgroup reviewed the current Board/Council/Committee minutes format and compared it against other successful Medical Center minutes reporting and tracking models. A format that facilitates successful reporting of results and tracking of actions (to ensure identification of improvement opportunities and correction of deficiencies) was selected and piloted in a Medical Staff Executive Council (MSEC) meeting on 11/18/11 and QEC on 11/15/11 and again on 12/20/11. A revised Committee minutes format will be implemented Medical Center wide by 01/27/12.

Recommendation 4. We recommended that processes be strengthened to ensure compliance with VHA requirements for utilization management and resuscitation.

Concur

Target date for completion: 12/15/11

Response: The process for ensuring compliance with the VHA requirements for Utilization Management was strengthened by using a VISN list of exemptions for Physician Utilization Management Advisors (PUMA) reviews. This list was approved by the MSEC on 8/23/11. Cases are submitted to the PUMA for review per VHA requirements.

Education for Nursing Coordinators and Nurse Managers was completed by 10/19/11 on their responsibility for completing code critiques. Audits of the code critiques are being performed monthly in Cardiopulmonary Resuscitation (CPR) Committee and feedback is being provided to staff to ensure compliance with the VHA requirements. A review of the CPR subcommittee documentation in the minutes was performed and the process was revised. Minutes now clearly show action, plan and defined responsibilities with target dates. The CPR Committee began reporting trended, aggregated and analyzed data on a quarterly basis at the 11/16/11 Critical Care Committee. CPR Committee is finalizing and implementing the CPR Committee Medical Center Memorandum **(**MCM) by 12/15/11 that clearly defines CPR committee responsibilities.

Recommendation 5. We recommended that processes be strengthened to ensure that EOC and IC Committee minutes document discussion of identified deficiencies and actions taken and include patient safety alerts, advisories, and adverse events.

Concur

Target date for completion: 01/03/12

Response: Patient safety alerts, advisories and adverse events are now reported to the EOC on a quarterly basis as of 10/26/11. EOC and IC minutes now include documenting actions, plans, discussions of identified deficiencies and trending. Tracking of deficiency corrections from EOC will be monitored by Administrative Executive Council (AEC) and IC will be monitored by MSEC quarterly.

Recommendation 6. We recommended that annual bloodborne pathogens training be completed and that compliance be monitored.

Concur

Target date for completion: 12/15/11

Response: Current Medical Center wide compliance rate 93%. The remaining employees will be trained by 12/15/11. To enhance compliance, bloodborne pathogen education was presented at the annual Safety Fair on November 9, 2011 and November 18, 2011 with 1095 employees completing the training. Supervisors are notified of non-compliant staff after the first day of non-compliance. Once a month, the bloodborne pathogen training non compliance report is sent to the respective ELT member for appropriate administrative action. Deficiencies are trended and reported to MSEC through the IC Committee monthly beginning 10/20/11.

Recommendation 7. We recommended that area-specific EOC inspections be completed that include reviews of equipment, medications, and nourishment refrigerators and that corrective action plans for deficiencies be monitored until fully resolved.

Concur

Target date for completion: 01/24/12

Response: For the refrigerators that lacked automated temperature tracking, the needed components were ordered; expected receipt and installation by 11/30/11. Enhanced training for members of the EOC team is scheduled for 12/13/11, with emphasis on reviewing equipment, medication expiration, and nourishment refrigerators. Deficiency trends identified by the EOC team will be reported through the AEC quarterly as of 01/24/12.

Recommendation 8. We recommended that processes be strengthened to ensure compliance with MH EOC Checklist requirements and that corrective action plans for deficiencies be monitored until fully resolved.

Concur

Target date for completion: 01/12/2012

Response: Full assessments of compliance with the Mental Health EOC check list were completed and will continue per VHA requirements. Deficiencies and corrective

actions are reported monthly to local Mental Health Service for action until fully resolved. Tracking of corrective action plans for MH EOC checklist deficiencies for October, November and December 2011, will be reported to EOC 01/12/12. These will then be reported by EOC to AEC who then will report to Leadership Board.

The following items listed were findings:

- A restraint bed with a sheet, pillow, and blanket (Completed 09/29/11)
- A seclusion room mattress with a zippered, non-breathable mattress cover (Completed 09/29/11)
- An unsecured fire equipment closet in a common hallway containing an unsecured fire extinguisher (Completed 09/29/11)
- An unsecured and unattended housekeeping cart containing plastic bags and brooms and mops with wooden and metal handles (Completed 09/29/11)

The following actions for removal were initiated however asbestos was found during the process and asbestos abatement is required and in process. Targets for completion are 12/31/11.

- Removable desk drawers in patient rooms (Target 12/31/11)
- Mechanical beds located in unsecured patient rooms distant from the nurses' station (Target 12/31/11)
- Standard office furniture in patient dining, day, and sleeping rooms (Target 12/31/11)
- Movable platform beds (Target 12/31/11)

Recommendation 9. We recommended that processes be strengthened to ensure that monthly SA RRTP self-inspections include documentation of compliance with privacy requirements.

Concur

Target date for completion: 01/12/12

Response: Local Standard Operating Procedure and self inspection forms were revised and approved as of 10/07/11 and includes assessment of privacy according to VHA regulations. Revised protocol for work orders needed for environmental safety was implemented, which includes a system to ensure follow up. Revisions and compliance tracking data will be reported quarterly to EOC starting 01/12/12 and quarterly to AEC.

Recommendation 10. We recommended that processes be strengthened to ensure that staff follow up with patients who express an interest in additional advance directive information.

Concur

Target date for completion: 01/31/12

Response: The Admission Assessment Nurse initiated an audit process for all new admissions to routinely audit the advance directive section of the assessment to ensure that Social Work consult was ordered and completed within the next business day. Immediate actions were initiated to ask more probing appropriate questions pursuing any advance directive that may be at home, educating patients and families, and documenting these discussions. Designated existing staff will be trained by 01/31/12. The Advance Directive MCM was approved 11/23/11. Audit results will be reported to Provision of Care Council as of the December meeting.

Recommendation 11. We recommended that processes be strengthened to ensure that staff make an effort to secure existing advance directives that are not on file at the facility.

Concur

Target date for completion: 01/31/12

Response: The process has been strengthened to ensure that existing advance directives are secured and scanned into Computerized Patient Record System (CPRS). For patients who state that their advance directives were previously completed, but the advance directive is not in the CPRS, the admission assessment nurse is explaining to the patient and entering a Social Work consult. Designated existing staff will be trained by 01/31/12. The audit tool and process (as referenced in Recommendation number 10) will include auditing the securing of advance directives and will be reported using the same process.

Recommendation 12. We recommended that processes be strengthened to ensure that when facility staff assist patients with completing advance directives, the patients are provided with copies and the medical records are documented.

Concur

Target date for completion: 01/31/12

Response: The Social Work Advance Directive template was modified 11/10/11 to include required fields to document that patients are provided with a copy of the advance directive. Designated existing staff will be trained by 01/31/12. The audit tool and process (as referenced in Recommendation number 10) will include auditing documentation of patients being provided with copies of completed staff assisted advance directives and will be reported using the same process.

Recommendation 13. We recommended that facility policy be updated to include a training component for staff responsible for notification and screening and for providing assistance with completion of advance directive forms.

Concur

Target date for completion: 01/31/12

Response: The Advance Directive MCM was modified and approved 11/23/11 to include a training component addressing assistance with completion of advance directive forms. The audience for the training was identified as the Social Work staff, Chaplain Staff and direct care Registered Nurses. A TMS module will be completed by 12/09/11 and designated existing staff will be trained by 01/31/12. Training compliance will be reported monthly to Provision of Care through the Ethics Committee.

Recommendation 14. We recommended that the facility appoint one MWV coordinator and update local policy to reflect this change.

Concur

Target date for completion: Completed 11/25/11

Response: The facility appointed one MWV coordinator on 11/18/11 and updated the local policy to reflect this change and approved on 11/25/11.

Recommendation 15. We recommended that the facility complete annual vulnerability assessments, trend data, and develop strategies to reduce or eliminate risks.

Concur

Target date for completion: 12/30/11

Response: A multidisciplinary workplace violence team is currently reviewing data to identify potential sources of violent behavior, determine the locations and individuals most likely to be at risk, and to develop strategies to reduce or eliminate risks. The workplace violence team will produce an Annual Workplace Violence Assessment that will be presented to Leadership Board through the AEC by 12/30/11.

Recommendation 16. We recommended that the facility develop and implement a workplace violence training plan for all staff in accordance with VHA requirements.

Concur

Target date for completion: 01/30/12

Response: The workplace violence training plan in development specifies appropriate education and training. Two of the known high-risk work groups (Emergency Department and Mental Health) are targeted for Prevention Management Disruptive

Behavior training beginning on 12/20/11. The workplace violence training plan will be implemented by 01/30/12, completed through the Learning Resource Service for designated staff commensurate with the degree of risk associated with their roles, responsibilities, and job site. Monitoring of this training will be ongoing, reported, and captured in Talent Management System. Training compliance shall be monitored by the Education Committee monthly and reported to AEC.

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