Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00276-135

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

March 18, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Charles George VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PE	pulmonary embolism
PR	peer review
PT/OT/KT	physical therapy/occupational therapy/kinesiotherapy
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 28, 2013.

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

- Medication Management – Controlled Substances Inspections
- Nurse Staffing
- Preventable Pulmonary Embolism

The facility's reported accomplishments were a system redesign project to improve the appropriateness of admissions to vascular surgery and oncology inpatient beds and reduce avoidable bed days of care and diversion hours and the initiation of multiple communication and transparency activities to improve employee satisfaction.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure actions from peer reviews are consistently completed and reported to the Peer Review Committee. Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners. Revise the local observation bed policy to include all required elements. Consistently scan results of non-VA purchased diagnostic tests into electronic health records. Require the blood usage and review process to include the results of proficiency testing and of peer reviews when transfusions did not meet criteria. Include applicable laboratory/clinical results post-transfusion and the assessment of outcome in documentation for blood product transfusions. Ensure actions taken when data analyses indicate problems or opportunities for improvement are consistently followed to resolution in utilization management, resuscitation, and blood/transfusion utilization reviews.

Environment of Care: Ensure Environment of Care Committee minutes reflect that actions taken in response to housekeeping deficiencies identified during environment of care rounds are tracked to closure. Implement actions to address high-risk areas, and document those actions in Infection Control Committee minutes. Remove expired commercial supplies from sterile storage rooms and treatment areas. Complete After-Installation Checklists for all ceiling lifts in the physical therapy/occupational therapy/kinesiotherapy clinic areas, and repair or remove damaged chairs from service in those areas.

Coordination of Care – Hospice and Palliative Care: Include a dedicated administrative support person on the Palliative Care Consult Team.

Long-Term Home Oxygen Therapy: Ensure that home oxygen program patients receive a timely annual re-evaluation after the first year.

Construction Safety: Conduct contractor tuberculosis risk assessments prior to construction project initiation.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–24, for the full text of the Directors' comments.) We consider recommendations 3, 11, and 13 closed. We will follow up on the planned actions for the open recommendations 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 quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. 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:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Nurse Staffing
- Preventable PE
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered selected facility operations for FYs 2010–2012 and FY 2013 through January 31, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Charles George VA Medical Center, Asheville, North Carolina,* Report No. 11-02721-47, December 22, 2011).

During this review, we presented crime awareness briefings for 119 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 258 responded. We shared survey results with facility managers.

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 Accomplishments

Admitting to Correct Level of Care

The facility determined that a high number of patients admitted to vascular surgery and oncology beds did not meet InterQual® criteria. A system redesign team identified that patient travel distance and the need for repetitive treatment contributed to the problem. In response, the facility instituted offsite lodging, expanded outpatient infusion hours, improved scheduling processes, and sought stakeholder buy-in. Results of those actions included a reduction in avoidable bed days of care for oncology and vascular patients from 1,481 in FY 2011 to 688 in FY 2012, a calculated cost avoidance of close to $2.2 million, and a reduction in diversion hours from 1,305 to 147 over the same time period. Veteran and provider satisfaction remained high. This project was awarded the VISN 6 Utilization Management System Redesign Award.

Employee Satisfaction Advancement

Improving employee satisfaction is a focused priority at the facility and has advanced significantly since 2010. To achieve this goal, the facility partnered with the National Center for Organizational Development to assess workplace themes, and as a result, developed an action plan to promote open communication and transparency across all services. All employees are invited to attend council meetings and may access meeting minutes to keep informed of issues and decisions that may affect their work area. Employees can attend civility training and quarterly town hall meetings or may participate in a monthly “Lunch with the Director.” Facebook, the Director’s blog, and newsletters also contribute to improving the transparency and open communication.

The VA-Truven Health Analytics ranking of satisfaction showed that the facility improved from 96th in FY 2010 to 15th in FY 2012 among all VA medical centers. Additionally, the facility’s 2010–2012 VA All Employee Survey comparison scores for Organizational Assessment led VISN 6 in all categories and showed improvement in 61 of the 62 survey questions.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
X	Corrective actions from the protected PR process were reported to the PR Committee.	Six months of PR Committee meeting minutes reviewed: • Of the 13 actions expected to be completed, 12 were not reported to the PR Committee.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Ten profiles reviewed: • Three FPPEs were not initiated.
X	Local policy for the use of observation beds complied with selected requirements.	• The facility's policy did not include how the service or physician responsible for the patient was determined or that each observation patient must have a focused goal for the period of observation.
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
	There was an EHR quality review committee, and the review process complied with selected requirements.	

NC	Areas Reviewed (continued)	Findings
	The EHR copy and paste function was monitored.	
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	Twenty-eight EHRs of patients who had non-VA purchased diagnostic tests reviewed: • Twenty-two test results were not scanned into the EHRs.
X	Use and review of blood/transfusions complied with selected requirements.	Four quarters of Transfusion Review Committee meeting minutes reviewed: • The review process did not include the results of proficiency testing or results of PRs when transfusions did not meet criteria. Thirty-four EHRs of patients who received blood products reviewed. There was no documentation of: • Applicable laboratory/clinical results post-transfusion in 6 EHRs (18 percent) • Assessment of outcome in 14 EHRs (41 percent)
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	Corrective actions were not consistently followed to resolution for utilization management, resuscitation, and blood/transfusion utilization reviews.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from PRs are consistently completed and reported to the PR Committee.

2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated.

3. We recommended that the local observation bed policy be revised to include all required elements.

4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

5. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing and of PRs when transfusions did not meet criteria.

6. We recommended that processes be strengthened to ensure that documentation for blood product transfusions includes applicable laboratory/clinical results post-transfusion and the assessment of outcome.

7. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in utilization management, resuscitation, and blood/transfusion utilization reviews.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the mental health, intensive care, and inpatient medical/surgical units; the CLC; the emergency department; the primary care (one and three), women's health, oncology, specialty, and mental health clinics; and the PT/OT/KT clinic areas. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Two months of EOC rounds documentation and 6 months of EOC Committee meeting minutes reviewed: • Minutes did not reflect that actions taken to correct housekeeping deficiencies identified during EOC rounds were tracked to closure.
X	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	Infection prevention risk assessment and 6 months of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect that actions were implemented to address high-risk areas.
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
X	Infection prevention requirements were met.	• Five of the 14 units/areas inspected had expired commercial supplies in sterile storage rooms and treatment areas.
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• An After-Installation Checklist was not completed for one of the three ceiling lifts in a PT/OT/KT clinic area.
X	Infection prevention requirements were met.	• Five chairs used by patients in the PT/OT/KT clinic areas had torn surfaces.
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

8. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to housekeeping deficiencies identified during EOC rounds are tracked to closure.

9. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Control Committee minutes document those actions.

10. We recommended that processes be strengthened to ensure that expired commercial supplies are removed from sterile storage rooms and treatment areas.

11. We recommended that processes be strengthened to ensure that After-Installation Checklists are completed for all ceiling lifts in the PT/OT/KT clinic areas.

12. We recommended that processes be strengthened to ensure that damaged chairs in the PT/OT/KT clinic areas are repaired or removed from service.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and interviewed key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 10 CS areas, the pharmacy, and the emergency drug cache. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records, and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
X	A PCCT was in place and had the dedicated staff required.	List of staff assigned to the PCCT reviewed: • An administrative support person had not been dedicated to the PCCT.
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT provided end-of-life training to all HPC staff as well as to selected non-HPC staff.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe, and goals of care for the end of life were addressed.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

13. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated Home Respiratory Care Program.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program (including 5 patients deemed to be high risk), and we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
	The Chief of Staff reviewed Home Respiratory Care Program activities at least quarterly.	
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
X	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	• Eighteen EHRs (51 percent) did not reflect that patients were re-evaluated in a timely manner after the first year.
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
	NC high-risk patients were identified and referred to a multidisciplinary clinical committee for review.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

14. We recommended that processes be strengthened to ensure that home oxygen program patients receive a timely annual re-evaluation after the first year.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on two selected units (acute care and long-term care).[6]

We reviewed relevant documents and 21 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 5-West and CLC-1 for 50 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2011, and September 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The unit-based expert panels followed the required processes.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The facility completed the required steps to develop a nurse staffing methodology by September 30, 2011.	
	The selected units' actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Preventable PE

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable PE.[7]

We reviewed relevant documents and 35 EHRs of patients with confirmed diagnoses of PE[a] January 1–June 30, 2012. We also interviewed key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." Because managers had already completed a protected PR for the one patient identified as having a potentially preventable PE, we made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable PE received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[a] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Construction Safety

The purpose of this review was to determine whether the facility maintained infection control and safety precautions during construction and renovation activities in accordance with applicable standards.[8]

We inspected the 1-West project. Additionally, we reviewed relevant documents and 20 training records (10 contractor records and 10 employee records), and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee infection control and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
X	Infection control, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	• The contractor tuberculosis risk assessment was not completed prior to the start of the project.
	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by multidisciplinary team members at the specified frequency and included all required elements.	
	Infection Control Committee minutes documented infection surveillance activities associated with the project(s) and any interventions.	
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendation

15. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Facility Profile (Asheville/637) FY 2012[b]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$263.6
Number of:	
• **Unique Patients**	36,721
• **Outpatient Visits**	395,978
• **Unique Employees[c] (as of last pay period in FY 2012)**	1,285
Type and Number of Operating Beds:	
• **Hospital**	119
• **CLC**	120
• **Mental Health**	18
Average Daily Census: (through August 2012)	
• **Hospital**	82
• **CLC**	75
• **Mental Health**	16
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Franklin/637GA Rutherfordton/637GB
VISN Number	6

[b] All data is for FY 2012 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for quarters 3–4 of FY 2011 and quarters 1–2 of FY 2012 and outpatient satisfaction scores for quarter 4 of FY 2011 and quarters 1–3 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011	FY 2012		
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	68.9	73.1	65.5	56.0	59.1	65.2
VISN	62.5	59.5	48.8	49.7	49.7	49.7
VHA	64.1	63.9	54.5	55.0	54.7	54.3

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[d] 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, 2008, and June 30, 2011.[e]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	13.8	13.7	11.0	19.0	23.4	19.5
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[d] 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. 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.

[e] 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: February 28, 2013

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 10AR MRS OIG CAP CBOC)

1. Thank you for the opportunity to provide a status report on the draft findings from the OIG CAP Review of the Charles George VAMC.

2. Attached please find the facility concurrences and responses to the findings from the review.

3. If you have questions or need further information, please contact Lisa Shear, QMO, VISN 6, at (919) 956-5541.

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

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 28, 2013

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)

1. I would like to express our appreciation to the Office of Inspector General (OIG) Survey Team for the professional and consultative nature of the review.

2. Attached please find our concurrences and responses to the findings from the review.

3. If you have additional questions or need further information, please contact me at (828)-298-7911 ext. 5224.

(original signed by:)
CYNTHIA BREYFOGLE, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that actions from PRs are consistently completed and reported to the PR Committee.

Concur

Target date for completion: April 1, 2013

Facility response: The Chief of Staff/Chair Peer Review Committee (PRC) sends a memo to the appropriate Service Chief or provider for each Level 2 and Level 3 case finding and indicates the expected actions as identified by the PRC. A confirmation that the action is complete is expected back through the Risk Manager to the Chief of Staff within 30 days. A tracking log is maintained of completed and outstanding actions and presented monthly to Medical Staff Executive Council as a standing agenda item. The Chief of Staff will have a follow-up meeting with the Service Chief/provider who has not responded within the allotted 30 days.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated.

Concur

Target date for completion: April 1, 2013

Facility response: All outstanding FPPEs for current staff hired from FY11 forward will be presented to Professional Standards Board (PSB)/Medical Staff Executive Council. All FPPE plans for new hires, additional privileges, and for cause are approved and recorded in the PSB minutes. Use of a tracking log for FPPEs due for initial privileges, additional privileges, and for cause was initiated January 8, 2013. The tracking log is distributed to Service Chiefs one week prior to each PSB to ensure timely reporting.

Recommendation 3. We recommended that the local observation bed policy be revised to include all required elements.

Concur

Target date for completion: Completed

Facility response: The Supervisor of Utilization Management revised the Observation Bed Policy to include verbiage from the National Observation Directive specific to provider/service assignment and observation treatment goals. This policy was

approved through the Utilization Management Committee February 15, 2013. Policy completed concurrence and was posted as of March 1, 2013.

Recommendation 4. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: May 1, 2013

Facility response: A Letter of Delegation was sent to the Salem Consolidated Fee Unit (CFU) authorizing scanning diagnostic test reports into Veterans' electronic health records. The Salem CFU concurred with implementation of the new process of scanning all reports to Asheville's VISTA Imaging package. Asheville Non-VA Care staff, will conduct a monthly audit and report to Medical Records Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing and of PRs when transfusions did not meet criteria.

Concur

Target date for completion: Completed

Laboratory proficiency testing was added as a Transfusion Utilization Review Committee standing agenda item beginning with the February 26, 2013, committee meeting. Proficiency testing deficiencies were addressed according to the standards of College of American Pathologists, and are tracked through the Laboratory Quality Management Council along with VACO's Regional Commissioner Assessment program. Copies of compliance of our participation are maintained in the blood bank records.

The Transfusion peer review process was clarified at the Transfusion Utilization Committee meeting of February 26, 2013, and re-education was completed at the Medical Staff Executive Council meeting that same date and by email to all clinical providers. The effectiveness of the re-education is monitored at the Transfusion Utilization Committee meeting in its review of met/not met for transfusion criteria.

Recommendation 6. We recommended that processes be strengthened to ensure that documentation for blood product transfusions includes applicable laboratory/clinical results post-transfusion and the assessment of outcome.

Concur

Target date for completion: Completed

Facility response: Clinical providers were re-educated on the post transfusion assessment process on February 26, 2013. The education included a reminder to providers that an assessment of transfusion outcome needs to be included in the clinical

note. A transfusion audit process is being implemented. The audit will include the applicable laboratory/clinical results post-transfusion and the assessment of outcome, which will be reported to the Transfusion Utilization Committee.

Recommendation 7. We recommended that processes be strengthened to ensure that actions taken when data analyses indicated problems or opportunities for improvement are consistently followed to resolution in utilization management, resuscitation, and blood/transfusion utilization reviews.

Concur

Target date for completion: April 1, 2013

Facility response: The template for the Cardiopulmonary Resuscitation Committee (CRC), the Utilization Management Committee (UM) and the Transfusion Utilization Committee (TUC) minutes, was modified to include the category of "Conclusion" after "Discussion." This modification enhances the documentation of discussion followed by an analysis that will improve capture of the opportunities and identified problems. From this analysis, specific actions will be identified and assigned to the responsible party. The identified conclusions, recommendations, actions, and action status will be reviewed for resolution at subsequent CRC, UM and TUC meetings and will be reported to the Medical Staff Executive Council.

Recommendation 8. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect that actions taken in response to housekeeping deficiencies identified during EOC rounds are tracked to closure.

Concur

Target date for completion: Completed

Facility response: Housekeeping will utilize the same environmental rounds tracking/input as the rest of the team (i.e. PDAs). These data will electronically roll-up to the EOC deficiency report and be included in EOC Committee minutes. This system began with the rounds conducted in the CLC1 on February 12, 2013. This will be reported monthly to the EOC Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that actions are implemented to address high-risk areas and that Infection Control Committee minutes document those actions.

Concur

Target date for completion: Completed

Facility response: The 2013 yearly risk assessments were reviewed. All areas rated as A (critical risk), B (high risk), and C (moderate risk) are actively monitored. During the Infection Control Committee meeting of February 26, 2013, all critical, high and

moderate risks were monitored and reported. The findings of monitoring critical and high risks areas are a standing agenda item. Actions to improve compliance begins immediately upon identifying an outlier. All moderate risk levels are monitored and reported quarterly unless there is an outlier. The Infection Control Committee reports findings to the Medical Staff Executive Council (MSEC).

Recommendation 10. We recommended that processes be strengthened to ensure that expired commercial supplies are removed from sterile storage rooms and treatment areas.

Concur

Target date for completion: April 1, 2013

Facility response: A sweep of the facility was completed by Nursing and Logistics February 1, 2013, to ensure there were no remaining expired commercial supplies. Environment of Care rounds by Nursing and Infection Control representatives are compiled and tracked by Nurse Executive Council and reported to the Provision of Care Council.

Recommendation 11. We recommended that processes be strengthened to ensure that After-Installation Checklists are completed for all ceiling lifts in the PT/OT/KT clinic areas.

Concur

Target date for completion: Completed

Facility response: Checklist for the PT lift is complete. A contract is in place for annual preventive maintenance. The contract was awarded October 1, 2012. Effective February 1, 2013, each lift was inspected and will be maintained per manufacturer's recommendations to ensure each lift has an after-install checklist completed. The maintenance contract will be renewed annually.

Recommendation 12. We recommended that processes be strengthened to ensure that damaged chairs in the PT/OT/KT clinic areas are repaired or removed from service.

Concur

Target date for completion: Completed

Facility response: The damaged chairs (torn surfaces), were replaced the week of February 1, 2013. Chair inspections were added to the environmental rounds checklist and conducted weekly throughout the facility. Deficiencies are tracked through the EOC deficiency report and reported to EOC Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that the PCCT includes a dedicated administrative support person.

Concur

Target date for completion: Completed

Facility response: The Program Support Assistant in Geriatrics and Extended Care is assigned 0.25 FTEE to provide administrative support to PCCT.

Recommendation 14. We recommended that processes be strengthened to ensure that home oxygen program patients receive a timely annual re-evaluation after the first year.

Concur

Target date for completion: April 1, 2013

Facility response: Beginning February 20, 2013, the Home Oxygen Coordinator runs a weekly report to identify annual evaluations due within the next 30 days. The home oxygen annual renewal appointments are now made two to four weeks prior to the expected re-evaluation date. The strengthened process will ensure that all annual evaluations are completed timely.

The Home Oxygen Team monitors the re-evaluations and reports monthly to the Home Respiratory Care Committee. The data are reported monthly to the Medical Staff Executive Council.

Recommendation 15. We recommended that processes be strengthened to ensure that contractor tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: Completed

Facility response: A revised tuberculosis risk assessment was developed and implemented, utilizing the OIG-provided sample as a template. The assessments are reported monthly through the Construction Safety Committee.

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, Records Management, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Directive 2008-007, *Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, February 4, 2008; VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, and the International Association of Healthcare Central Service Material Management.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic were:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] The reference used for this topic was:
- VHA Office of Analytics and Business Intelligence, *External Peer Review Technical Manual*, FY2012 quarter 4, June 15, 2012, p. 80–98.

[8] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and Occupational Safety and Health Administration (OSHA) regulations.