Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03075-137

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

June 2, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of February 9–13, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Charles George VA Medical Center (the medical center), Asheville, NC. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 319 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in four of the activities reviewed. For these activities, the medical center needed to ensure that:

- Staff comply with local policy on cardiopulmonary resuscitation (CPR) training.
- Privileges for contracted physicians do not exceed the contract period.
- Pharmacy managers evaluate medication redistribution practices to ensure that medications are safe for patients.
- Staff document patients' informed consent for transfer and advanced directive status prior to transfer to another facility.
- Nurses document the effectiveness of pain medications within the timeframe established by local policy.

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

- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- Suicide Prevention Program.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Susan Zarter, Associate Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Acting Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The medical center is a general medical and surgical facility located in Asheville, NC, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at one community based outpatient clinic (CBOC) in Franklin, NC. The medical center is part of VISN 6 and serves a veteran population of about 99,000 throughout 19 counties in North Carolina.

Programs. The medical center provides primary, medical, surgical, mental health (MH), specialty, and long-term care services. It has 116 hospital beds and 120 community living center (CLC)[1] beds.

Affiliations and Research. The medical center is affiliated with the Duke University School of Medicine and other local institutions and provides training for medical residents and for students in allied health discipline programs, such as dental, nursing, pharmacy, and physician assistant. In fiscal year (FY) 2008, the medical center research program had approximately 25 projects and a budget of $100,550. Important areas of research included cancer, cardiovascular diseases, diabetes related disorders, and dyslipidemia.

Resources. In FY 2008, medical care expenditures totaled $206 million. The FY 2009 medical care budget is approximately $212 million. FY 2008 staffing was 1,234 full-time employee equivalents (FTE), including 89 physician and 269 nursing FTE.

Workload. In FY 2008, the medical center treated 31,673 unique patients and provided 30,385 inpatient days in the hospital and 26,800 inpatient days in the CLC. The inpatient care workload totaled 4,633 discharges, and the hospital average daily census was 83. The CLC average daily census was 73. Outpatient workload totaled 272,439 visits.

Objectives and Scope

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

[1] A CLC (formerly called a nursing home care unit) provides a homelike environment to eligible veterans who require a nursing home level of care.

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

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

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

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- QM.
- Suicide Prevention Program.
- SHEP.

The review covered medical center operations for FY 2008 and FY 2009 through February 9, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Asheville, North Carolina,* Report No. 05-03384-70, February 2, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 319 employees. These briefings covered procedures for reporting suspected criminal activity

to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for 11 of the 13 program activities reviewed. However, we identified deficiencies in the following areas.

CPR Training. At the time of our visit, only 88 percent of applicable staff had documentation of current CPR training. Local policy requires certain staff to receive CPR training so that they can initiate appropriate and skilled emergency interventions during life-threatening cardiopulmonary events.

Contract Physician Privileging. We found that 8 (73 percent) of 11 contracted physicians were granted privileges which exceeded the length of their contracts. The contract periods ranged from June 2007 to January 2009. VHA policy[2] states that privileges granted to contracted physicians may not extend beyond the contract period.

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Recommendation 1 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff comply with local policy on CPR training.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that they have revised the local CPR training policy, created a consolidated tracking database, scheduled training, and instituted a reminder system. They will record training and report compliance to management quarterly. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that privileges for contracted physicians do not exceed the contract period.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that they will present contract terms to the Physician Standards Board when clinical privileges are requested so that privileges coincide with the contract period. They will advise clinical services to establish contract terms based on projected needs. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the locked MH unit, one CLC unit, an acute care unit, the surgical unit, and the intensive care units. Overall, we found that the medical center maintained a generally clean and safe environment. The infection control program monitored exposures and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. Managers on the locked MH unit complied with safety regulations, and staff were trained to identify environmental hazards. However, we identified the following condition that required attention.

Medication Safety. We found five oral inhalers that had been dispensed to individual patients stored in the acute care

medication room. Staff told us that the inhalers were unused and would be redistributed. Two inhalers still had labels with the original patients' names, and three had blank labels over the names. We found that none of the inhalers had an original, intact package seal. To ensure patient safety, the American Society of Hospital Pharmacists recommends that only unused medications with an original package seal be redistributed. VHA policy[3] states that unused medications should be returned to the pharmacy.

Recommendation 3 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that pharmacy managers evaluate medication redistribution practices to ensure that medications are safe for patients.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that they purchased tamper-evident tape, educated staff on dispensing procedures, and followed up with staff to ensure compliance. They will also update the local policy. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether the medical center's emergency room (ER) complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and nursing staff competencies. In addition, we inspected the ER environment for cleanliness and safety.

The ER is located in the main hospital building and is open 24 hours per day, 7 days per week, as required for ER designation. The emergency services provided are within the medical center's patient care capabilities. In addition, the medical center has a procedure in place for the management of patients whose care may exceed the medical center's capability.

We toured the ER and found the environment to be safe for the delivery of patient care. We determined that nurse staffing plans met local requirements and that nursing competencies were appropriately documented. We examined three pieces of medical equipment and found that preventive maintenance was completed, as required. We reviewed the medical records of five patients who presented

[3] VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.

to the ER with acute MH conditions and found that all five patients were managed appropriately. However, we identified the following condition that required attention.

Inter-Facility Transfers. We reviewed the medical records of three patients transferred from the ER to other medical facilities and found that two of the medical records did not contain documented evidence of patient informed consent for transfer or advanced directive status. VISN policy requires that staff document patients' informed consent for transfer and advanced directive status prior to transfer to another facility. While we were onsite, managers modified the inter-facility transfer template.

Recommendation 4 We recommended that the VISN Director ensure that the Acting Medical Center Director requires staff to document patients' informed consent for transfer and advanced directive status prior to transfer to another facility.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that they corrected the template to ensure that the required elements for transfer are documented. They will conduct chart reviews to monitor compliance and will re-educate staff if deficiencies are identified. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes on the acute care, surgical, intensive care, MH, and CLC units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. We found that reconciliation of controlled substances discrepancies at the unit level was adequate. We indentified one area that needed improvement.

Pain Medication Effectiveness. We found that documentation of PRN (as needed) pain medication effectiveness did not comply with local policy. We reviewed 228 PRN pain medication doses and found effectiveness

documented within 2 hours, as required by local policy, for only 83 (36 percent) doses.

Recommendation 5 We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses document the effectiveness of pain medications within the timeframe established by local policy.

The VISN and Acting Medical Center Directors agreed with the findings and recommendation and reported that they revised the local policy and educated staff on PRN effectiveness documentation requirements. They will monitor compliance and report the results to leadership monthly. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. These requirements include documentation of current licensure, completed competencies, and VHA information security training and verification of background checks.

We found the required documentation for all 10 contracted RNs that worked at the medical center from January 2008 to January 2009. In January 2009, the medical center implemented a local policy specific to contract nurses. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to optimal patient outcomes.

We reviewed the medical records of 12 inpatients who had consultations ordered and performed and found that, in general, inpatients received consultative services within acceptable timeframes.

We determined that clinicians appropriately managed all 12 intra-facility transfers. We found transfer notes from sending to receiving units and documentation that nursing

assessments were performed by the receiving units in accordance with established timeframes.

We reviewed 16 medical records of discharged patients and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood the instructions. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPC) at facilities and very large CBOCs,[4] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[5] documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the medical center's SPC, MH providers, and the Risk Manager, and we reviewed pertinent policies and the medical records of three patients determined to be at risk for suicide. We found that senior managers had appointed one full-time SPC and had hired a full-time Suicide Prevention Case Manager. The SPC fulfilled the required functions of the position, and documentation was complete in all medical records reviewed. We made no recommendations.

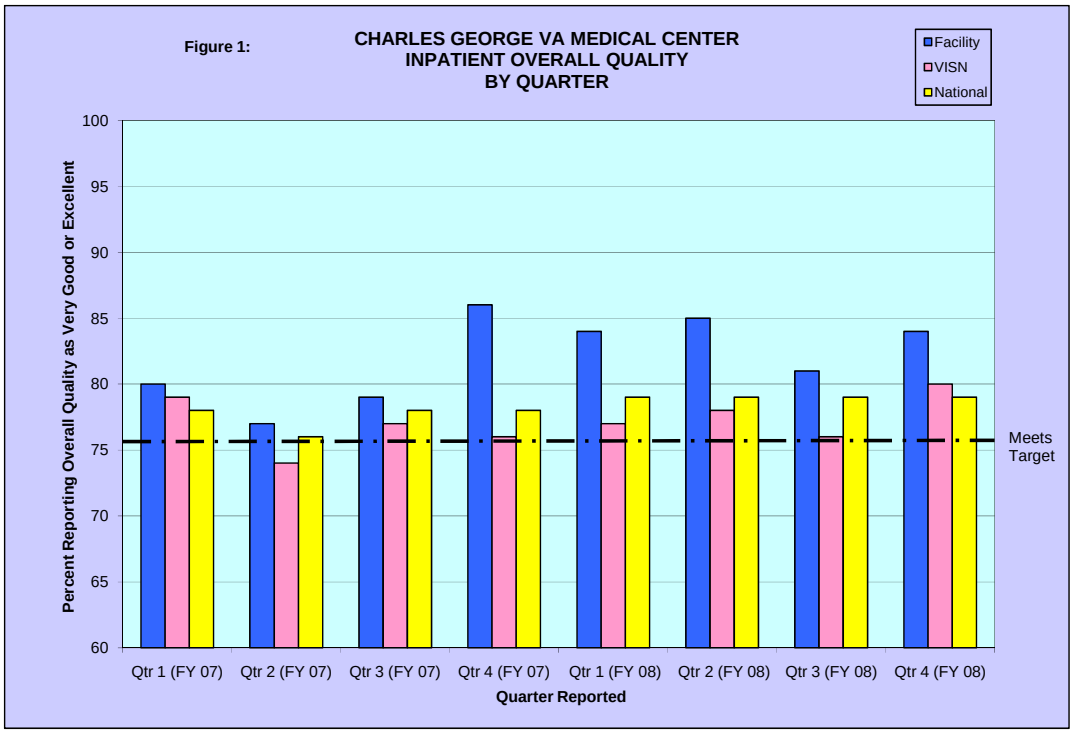
Survey of Healthcare Experiences of Patients

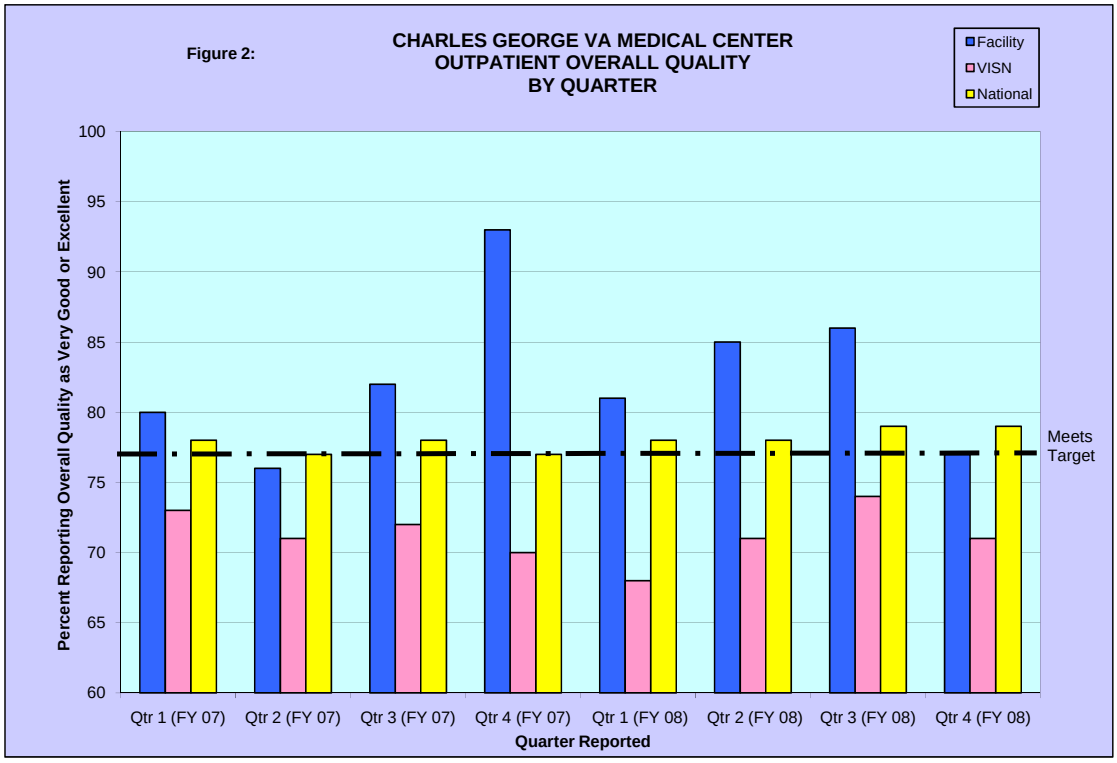
The purpose of this review was to assess the extent that VHA facilities use SHEP data to improve patient care, treatment, and services. SHEP is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

[4] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[5] A Category II PRF is an alert mechanism that is displayed prominently in medical records.

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

Figure 1:





The medical center met or exceeded the established target for inpatient overall quality in all of the last 8 quarters of available data and met or exceeded the established target for outpatient overall quality in 7 of the last 8 quarters of available data. It has consistently been a customer satisfaction leader within the VISN.

The medical center had a multidisciplinary Patient Satisfaction Committee that analyzed and reported SHEP survey results. Managers had initiated improvement actions, which included developing a service-level patient advocate program, creating a telephone call management center, and implementing other goal-sharing activities. Despite the medical center's impressive customer satisfaction scores, managers and staff continue to seek opportunities for improvement and to initiate corrective actions. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **April 27, 2009**

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

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

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

Thru: Director, Management Review Service (10B5)

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

2. If you have any questions, please contact Mr. Hitch, Interim Director Charles George VA Medical Center directly at (828) 299-5999.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 4/17/09

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

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

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

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

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

(original signed by:)

Walter E. Hitch

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that staff comply with local policy on CPR training.

Concur **Target Completion Date**: **9/25/09**

- Revise and republish CPR MCM by April 15, 2009 (now in final signature routing.).
- Create one consolidated tracking database of all clinical staff needing BLS/ACLS by April 15, 2009, and update each pay period with that pay period's gains and losses.
- Schedule blitz of BLS training in May and June for all required clinical staff not currently BLS competent.
- With creation of new Education Service, institute system of reminder 90 days in advance of expiration of BLS/ACLS to individual and service chief/supervisor by June 1, 2009.
- Record all BLS/ACLS training in TEMPO as well as ACCESS database including new hires by June 1, 2009.
- Quarterly monitoring of compliance reported (total and by service/section) to Education Council and Leadership Board starting July 2009.

Recommendation 2. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that privileges for contracted physicians do not exceed the contract period.

Concur **Target Completion Date: 4/30/09**

- Medical Staff Office to present contract terms of hire at time of request for clinical privileges and medical staff appointment at the PSB (Completed 3/15/09).
- Set effective date of privileges to coincide with contract terms (Completed 3/15/09).
- Advise clinical services re: requirements in order to structure contract agreements according to projected need. (Target date 4/30/09)

Recommendation 3. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that pharmacy managers evaluate medication redistribution practices to ensure that medications are safe for patients.

Concur **Target Completion Date: 5/20/09**

- Purchase tamper-evident tape for placement prior to dispensing foward use. (Completed 2/20/09)
- Educate staff by e-mail, on proper procedure for dispensing and that there should be no outpatient labeling present on packaging. (Completed 3/23/09)
- Follow-up with staff two weeks after education to ensure proper procedure is adhered to. (Completed 4/13/09)
- Update MCM to include new process. (Target date 5/20/09)

Recommendation 4. We recommended that the VISN Director ensure that the Acting Medical Center Director requires staff to document patients' informed consent for transfer and advanced directive status prior to transfer to another facility.

Concur **Target Completion Date: 04/16/09**

- The template was corrected at time of the inspection visit; now the consent for transfer and the advance directive status are required fields. (Completed 2/11/09)
- Goal: 90 days or 30 chart reviews to ensure compliance. (Completed 04/16/09 – 30 chart reviews)
- If deficiencies are identified, then re-educate and continue monitoring for an additional 90 days to assure problem is corrected.

Recommendation 5. We recommended that the VISN Director ensure that the Acting Medical Center Director requires that nurses document the effectiveness of pain medications within the timeframe established by local policy.

Concur **Target Completion Date: 6/19/09**

- Codification: April 1, 2009: MCM No. 118-5: Administration of medicines, alcohols, and controlled substances was revised reflecting changes in PRN effectiveness report and documentation. In concurrence 4/8/09.
- Staff Education: Staff notified (verbally and via e-mail) on the one hour time frame to evaluate and document PRN effectiveness. Staff administering medication will print a PRN effectiveness report twice during a shift. (Completed 2/16/09)

- House-wide education will begin on evaluation to include the following topics: (1) Revision of MCM 118-5 poster presentation on complete policy change with a post test evaluation. (Completed 4/13/09) (2) Evaluating PRN effectiveness of pain medications and narcotics (Target date for implementation April 27, 2009) (3) Evaluating PRN effectiveness of medications to treat nausea, acid reflux, insomnia, constipation, etc. (miscellaneous group of medications) (Target date for implementation May 11, 2009). Education of the above topics will be done with poster presentation which will be available to staff at two week intervals.
- Nurse Managers will: (1) assign PRN effectiveness monitoring to night shift champion starting April 6 and reported each morning to nurse manager (Completed 4/6/09) (2) evaluate PRN effectiveness documentation and refer educational needs of staff who comply with MCM 118-5 changes to document to Clinical Nurse Specialist/Nurse Educator for follow-up (Completed 4/6/09) (3) follow up with Chief, Respiratory Therapy (users of BCMA) on non-compliance for members of that service.
- The Associate Director, Patient Care Services will provide oversight of monitoring the effectiveness of these actions and will report monthly to peers in the Executive Leadership Team beginning with a May 2009 report.

OIG Contact and Staff Acknowledgments

Contact	Susan Zarter, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Contributors	Audrey Collins-Mack, Team Leader Nancy Albaladejo Victoria Coates Melanie Cool Tishanna McCutchen Bobby Kirby, Office of Investigations

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