Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00044-138

Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

April 27, 2010

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 January 11–15, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the William Jennings Bryan Dorn VA Medical Center (the medical center), Columbia, SC. 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 119 employees. The medical center is part of Veterans Integrated Service Network (VISN) 7.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in seven of the activities reviewed. For these activities, the medical center needed to ensure compliance with Veterans Health Administration (VHA) policies and other external standards related to:

- Reusable Medical Equipment (RME)
- QM Program
- Magnetic Resonance Imaging (MRI) Safety
- Coordination of Care (COC)
- Environment of Care (EOC)
- Medication Management
- Physician Credentialing and Privileging (C&P)

The medical center complied with selected standards in the following activity:

- Suicide Prevention Safety Plans

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable corrective actions and improvement plans. (See Appendixes A and B, pages 18–25, 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 tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics located in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The medical center serves a veteran population of about 410,000 throughout South Carolina and is part of VISN 7.

Programs. The medical center provides medical, surgical, mental health (MH), geriatric, rehabilitative, and home health services. It has 95 operating hospital beds and 75 community living center (CLC) beds.

Affiliations and Research. The medical center is affiliated with Palmetto Health and with the University of South Carolina's School of Medicine and supports 65 medical resident positions. The medical center has sharing agreements with Shaw Air Force Base and Fort Jackson Army Base. In fiscal year (FY) 2009, the medical center research program had 52 projects and a budget of $693,000. Important areas of research included post-traumatic stress disorder, pharmacological interventions for cancer, and renal disease.

Resources. In FY 2009, medical care expenditures totaled $301 million. The FY 2010 medical care budget is $315 million. FY 2009 staffing totaled 1,920 full-time employee equivalents (FTE), including 128 physician and 420 nursing FTE.

Workload. In FY 2009, the medical center treated 65,738 unique patients and provided 27,884 inpatient days of care in the hospital and 13,836 inpatient days of care in the CLC. The inpatient care workload totaled 5,010 discharges, and the average daily census, including CLC patients, was 114. The outpatient workload totaled 707,533 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:

- 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:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM Program
- RME
- Suicide Prevention Safety Plans

The review covered medical center operations for FY 2009 and FY 2010 through January 11, 2010, and was done in accordance with OIG standard operating procedures (SOPs) for CAP reviews. We also followed up on selected recommendations from two previous reports:

- *Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* Report No. 07-00163-128, May 10, 2007. The medical center had corrected all health care findings from our prior CAP review.

- *Healthcare Inspection – Supply, Processing, and Distribution Issues and Quality of Care Concerns, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* Report No. 07-02902-78, February 20, 2008. The medical center had implemented appropriate actions to address all recommendations in our report.

During this review, we also presented fraud and integrity 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.

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. The activity in the "Review Activity Without Recommendations" section had no findings requiring corrective actions.

Results

Review Activities With Recommendations

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA managers and staff are responsible for minimizing patient risk and maintaining an environment that is clean and safe. The medical center's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet standards established by VHA, the Association for the Advancement of Medical Instrumentation, the Occupational Safety and Health Administration (OSHA), and The Joint Commission (TJC).

We inspected the SPD reprocessing area and sterile supply area and the satellite reprocessing areas for cardiology, gastroenterology (GI), genitourinary, hemodialysis, and the operating room. We determined that the medical center had established appropriate guidelines and monitored compliance with those guidelines. However, we identified the following areas that needed improvement.

Competencies. VHA policy[1] requires that competencies are evaluated annually on the set-up, use, reprocessing, and maintenance of specific RME. We reviewed competency folders of 18 SPD employees and found that 9 (50 percent) folders did not contain documentation of one or more annual competencies for the following RME: (a) dental instruments, (b) orthopedic instruments, (c) GI biopsy forceps, and (d) transesophageal echocardiography probes.

Environment Inspections. VA policy[2] requires that medical centers maintain clean and safe environments that meet specific air quality and other requirements. During our inspections we found that:

- The SPD reprocessing area did not maintain negative air pressure, as required.
- The GI clinic reprocessing area did not have the required six air exchanges per hour.
- The SPD clean storage area's humidity levels fell below the required 35 percent for all but 1 day between December 22, 2009, and January 12, 2010. During our tour, the reading was 28.5 percent.

Medical Record Reviews. Local policy requires the medical record of a patient undergoing a flexible endoscopic procedure to contain documentation of the RME serial number and the name of the provider who performed the procedure. We reviewed 20 medical records and found appropriate documentation in all 10 colonoscopy procedure notes. However, we did not find required documentation in any of the 10 cystoscopy procedure notes.

Committee Reporting. VHA policy[3] requires specific RME elements to be reported to an executive-level committee. We found that the medical center had not instituted a process for the reporting of required elements, including staff competency validation, SOP compliance, infection prevention and control monitoring, and risk management.

[1] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment Through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[2] VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.
[3] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all RME competencies are evaluated annually and documented.

The VISN and Medical Center Directors agreed with the finding and recommendation. All nurse managers, the Chief of SPD, and applicable service line leaders will certify annually to the RME Committee that staff members who clean RME have been evaluated through annual competency review. Additionally, SPD staff members who clean and sterilize critical RME will receive training and have competency review as new items are identified and SOPs are developed. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director implements corrective actions to ensure that negative air pressure is maintained in the SPD reprocessing area.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will install an additional exhaust to create negative pressure until a construction project is arranged to correct the air handler. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director implements corrective actions to ensure six air exchanges per hour in the GI reprocessing area.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center adjusted the air handling systems to ensure adequate air exchange. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the appropriate humidity level is maintained in the SPD clean storage area.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will equip the SPD clean storage area with a humidifier, controls, and alarms until a construction project is arranged to correct the

air handler. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that the medical records of patients undergoing flexible endoscopic procedures contain documentation of the RME serial number and the name of the provider who performed the procedure.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center implemented procedures to document the flexible endoscope serial numbers and provider names. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires reporting of staff competency validation, SOP compliance, infection prevention and control monitoring, and risk management activities to an executive-level committee.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will require that units and departments report the status of inventories, position descriptions, functional statements, infection prevention and control monitoring, and risk management activities to the Health Systems Council. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management Program

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 structures were in place for 10 of the 12 program activities reviewed; however, we identified deficiencies in the following areas.

Peer Review Committee. VHA policy[4] requires that the Peer Review Committee (PRC) identify opportunities for improvement during the peer review process and monitor corrective actions until they are completed. Minutes from the medical center's PRC reflected improvement opportunities, such as process reviews and medical record template revisions; however, PRC minutes did not track the actions through to completion.

Cardiopulmonary Resuscitation and Its Outcomes. TJC requires the collection of data on resuscitation outcomes to identify opportunities for improvement in the delivery of quality care, treatment, and services. In addition, VHA policy[5] requires that each medical center have a process in place to ensure that designated clinically active staff have current cardiopulmonary resuscitation (CPR) certification. The medical center did not collect ongoing PI data on resuscitation events and outcomes nor was there a process in place to review staff compliance with CPR certification requirements.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to document all required committee activities.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center has changed the minutes and agenda formats to delineate open, pending, and completed action items. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires the collection of data on resuscitation events and outcomes to identify opportunities for improvement.

The VISN and Medical Center Directors agreed with the finding and recommendation. Effective January 2010, resuscitation data will be submitted quarterly to the Health Systems Council. The implementation plans are acceptable,

[4] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[5] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires implementation of a tracking system to ensure that designated clinically active staff members comply with CPR certification requirements.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center has implemented CPR certification tracking and renewal reminder systems. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined patient medical records and staff training records, reviewed relevant policies, and interviewed key staff. We determined that the medical center had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by TJC. Patients in the magnet room were directly observed at all times and had access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have been conducted in the MRI area.

Before MRI studies are performed, patients are interviewed and screened for metal implants, tattoos, and other objects that could be affected by the magnet. We reviewed the medical records of patients who underwent MRI studies in November 2009 and found that screening responses were not documented in 8 (80 percent) of the 10 records, as required by TJC. However, in December, medical center staff changed the screening response policy to utilize iMedConsent™ documentation.[6] We verified that the process was implemented and effective; therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

[6] With iMedConsent™ technology, clinicians can review VA forms onscreen with patients, capture signatures with an electronic signature pad, and generate a note in VHA's Computerized Patient Record System.

Safety Education. TJC recommends that annual MRI safety education be provided to all staff who may enter the MRI area, including housekeepers and police officers. Managers told us that the required annual Level 1 MRI safety education had not been provided to MRI or non-MRI staff members.

Security and Safety. TJC recommends that Zone 3 access be physically restricted. Before our visit, medical center staff conducted a risk assessment, identified that Zone 3 was accessible, and placed a chain across the hallway to deter entry. However, unauthorized staff or patients could unhook the chain to enter Zone 3.

Preventive Maintenance. Although required by a contract, we were told that the contracting company had not provided preventive maintenance of the MRI suite panic alarm.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires annual MRI safety education to be provided to appropriate staff.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center completed Level 1 and Level 2 training for designated staff and will make future Level 1 and Level 2 training available through an electronic education program. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires Zone 3 access to be physically restricted in accordance with TJC's guidance.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will assure that Zone 3 is attended during operational hours and will conduct a risk assessment regarding the impact of a physical barrier to Zone 3. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires preventive maintenance on the MRI panic alarm to be conducted in accordance with contract requirements.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center initiated preventive maintenance alarm checks, and the records will be maintained by Police Service. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA's and TJC's requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 18 patients discharged during the months of October and November 2009 and found deficiencies in 2 (11 percent) of the records. Both records were missing discharge diet orders, which are required by VHA.[7] Because managers agreed with the findings and planned to take appropriate actions, we made no recommendation for this finding.

VHA policy[8] requires that clinical staff complete VA Form 10-2649A, "Inter-Facility Transfer Form," and VA Form 10-2649B, "Physician Certification and Patient Consent for Transfer Form," when a patient is transferred to another facility. We reviewed the medical records of 10 patients transferred to another facility during the time period of July–November 2009. While we found that none of these records contained either of the required forms, staff documented all relevant transfer information, such as the reason for transfer, in progress notes. We reviewed our findings with medical center managers who plan further evaluation and action; therefore, we made no recommendation. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy also requires that medical centers have a policy that ensures the safe, appropriate, and timely transfer of patients. Additionally, VHA requires inter-facility transfers to be monitored and evaluated as part of the QM program. We determined that the medical center had an appropriate inter-facility transfer

[7] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.
[8] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

policy; however, we did not find evidence that the QM program monitored patient transfers.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires that staff monitor and evaluate patient transfers as part of the QM program.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center will provide staff education and revise the process to ensure completion of appropriate forms. Also, quarterly reports will be provided to the Health Systems Council. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA's, OSHA's, the National Fire Protection Association's, and TJC's standards.

We inspected the recently renovated Warrior's Walk hospice unit and the CLC neighborhoods of Wateree and Congaree. The CLC neighborhoods housed a barber shop, ice cream parlor/wet bar with a baby grand piano, laundromat, fix-it shop, and library as well as a spa with warming cabinets for bath towels. A large eat-in kitchen with a bay window, a living room with a faux fireplace, and a fenced-in back yard created inviting gathering spaces. We found that these environments were safe and clean with features that foster comfort, socialization, and meaningful use of time.

We also inspected the hemodialysis (5N), medical (4W), surgical (2W), locked MH, coronary care, medical intensive care, surgical intensive care, and progressive care units; the emergency department; and two primary care (red and white) clinics. The medical center maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were met, and risk assessments were in compliance with VHA standards. However, we identified the following condition that needed improvement.

Training. VHA policy[9] requires that locked MH unit employees and Multidisciplinary Safety Inspection Team members complete annual training on environmental hazards that represent a threat to suicidal patients. We reviewed appropriate staff training records for November 2008–November 2009 and found that none of the records contained documentation of the required annual MH environmental hazards training.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that all appropriate staff receive annual training on MH environmental hazards, as required.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center distributed education information to staff members who work in MH inpatient and outpatient areas. Training documentation will be maintained by the Suicide Prevention Program Coordinator. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The medical center had implemented a practice guideline governing the management of hemoglobin levels in chronic renal disease patients who receive erythropoiesis-stimulating agents (ESAs).[10] We found documentation showing that clinicians had appropriately identified and addressed elevated hemoglobin levels for 9 (90 percent) of the 10 patients whose medical records we reviewed. We referred our concerns regarding the remaining case to the Chief of Medicine for evaluation and action, as indicated. Also, the pharmacy operates 24 hours a day, 7 days a week and has qualified staff to answer questions. However, we identified one area that needed improvement.

[9] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," general instructions, January 4, 2010.
[10] ESAs are used to treat anemia by stimulating the bone marrow to make red blood cells.

CLC Influenza Vaccinations. VHA policy[11] requires several elements to be documented for each influenza vaccine given, including patient education using the Centers for Disease Control (CDC) and Prevention Vaccine Information Statements. We reviewed the medical records of 10 CLC residents who received the influenza vaccine in September or October 2009. We found that 8 (80 percent) records did not contain documentation of education using CDC Vaccine Information Statements.

Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document patient vaccine education, as required by VHA.

The VISN and Medical Center Directors agreed with the finding and recommendation. CLC staff will document vaccination education using an electronic medical record template, and the medical center will review staff compliance with the process. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[12] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed C&P files and profiles of selected physicians who were granted either initial privileges or renewal of privileges in the past 12 months. We found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

Focused Professional Practice Evaluation. Focused Professional Practice Evaluation (FPPE) is a process whereby the medical center evaluates the privilege-specific competence of a practitioner, such as a newly hired physician who does not have documented evidence of competently performing the requested privileges at the facility. FPPE should be considered at the time of initial appointment or when new privileges are requested. We

[11] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.
[12] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

found that the C&P files and profiles for two of the four applicable physicians did not contain evidence of FPPE.

Ongoing Professional Practice Evaluation. Ongoing Professional Practice Evaluation (OPPE) is a process that reevaluates privilege-specific competence for all privileged physicians. We found that three of the seven physician profiles reviewed did not contain adequate supporting evidence of OPPE data for the 2-year period prior to reprivileging.

Recommendation 16 We recommended that the VISN Director ensure that the Medical Center Director requires that privileges are granted in accordance with VHA requirements.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center modified the OPPE process to include the numbers of high-risk and/or low-volume procedures to be reported to the Medical Executive Sub-Council. Staff will initiate an FPPE when a provider requests an increase in privileges and will complete an OPPE when a licensed independent practitioner changes from fee basis to staff appointment. Additionally, staff will present weekly reports at the clinical supervisors' meeting. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior-oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[13]

[13] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

A previous OIG review of suicide prevention programs in VHA facilities[14] found a 74 percent compliance rate with safety plan development. The issues identified in that review were that suicide safety plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

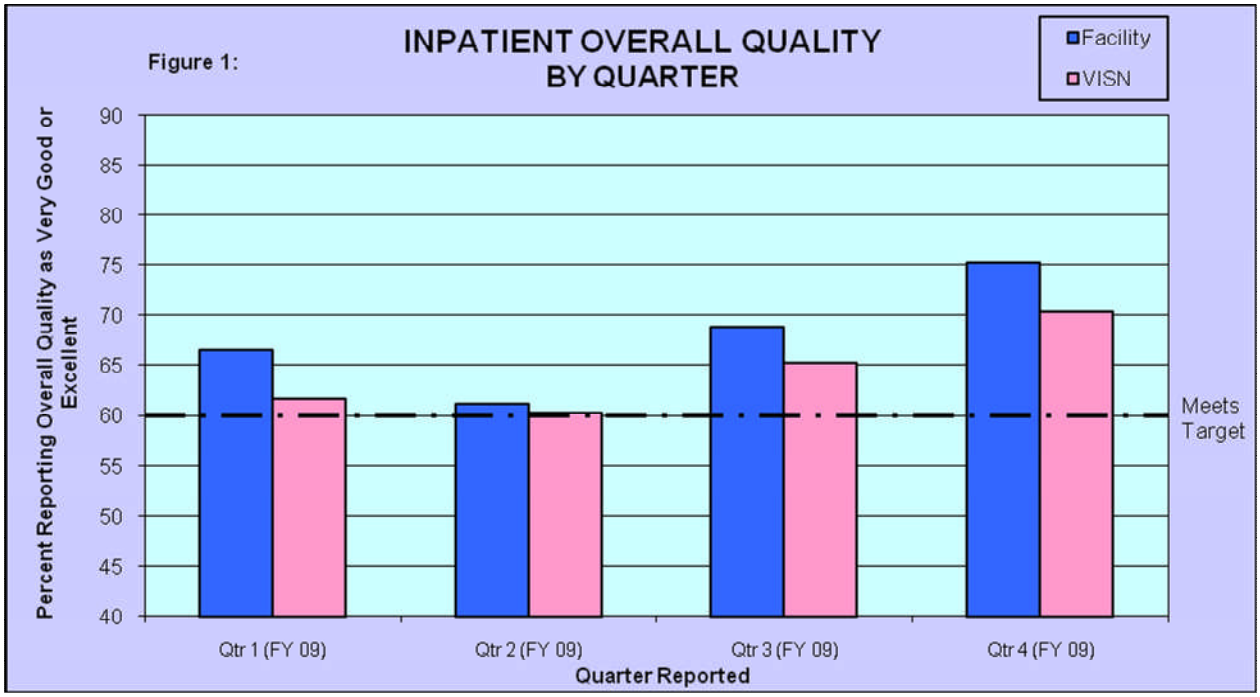
We reviewed the medical records of 9 patients assessed to be at high risk for suicide within the past 6 months and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

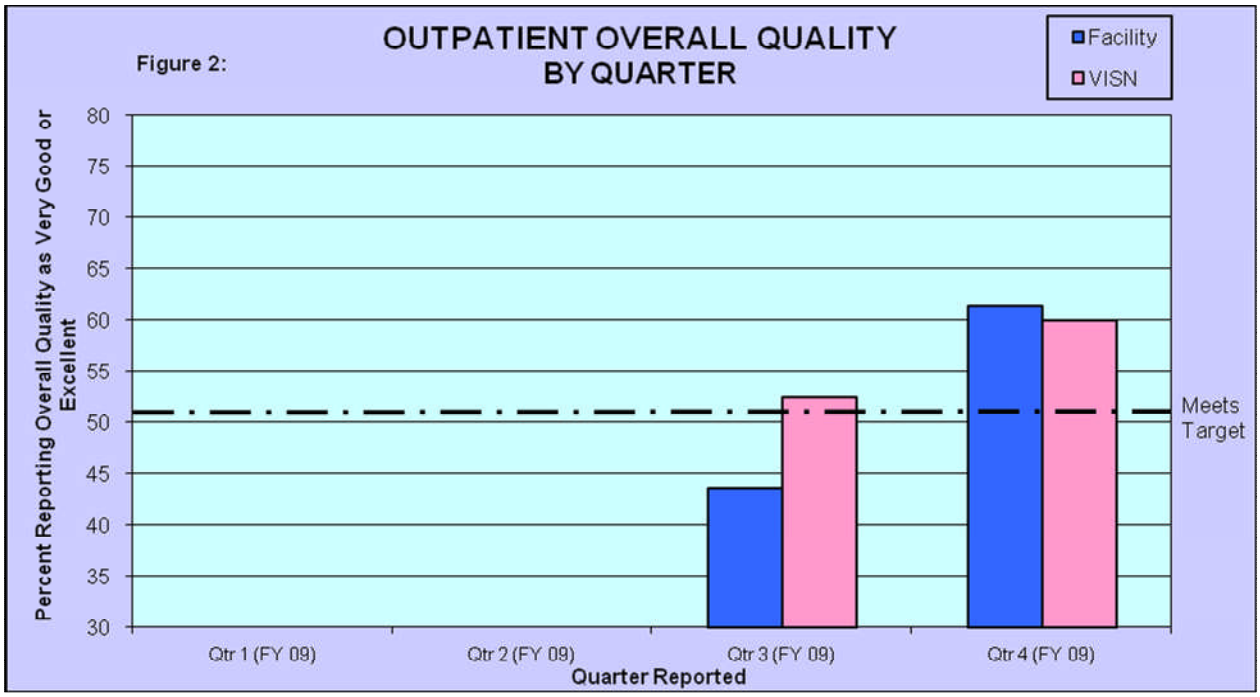
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[15] The target scores are noted on the graphs.

[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*; Report No. 09-00326-223; September 22, 2009.

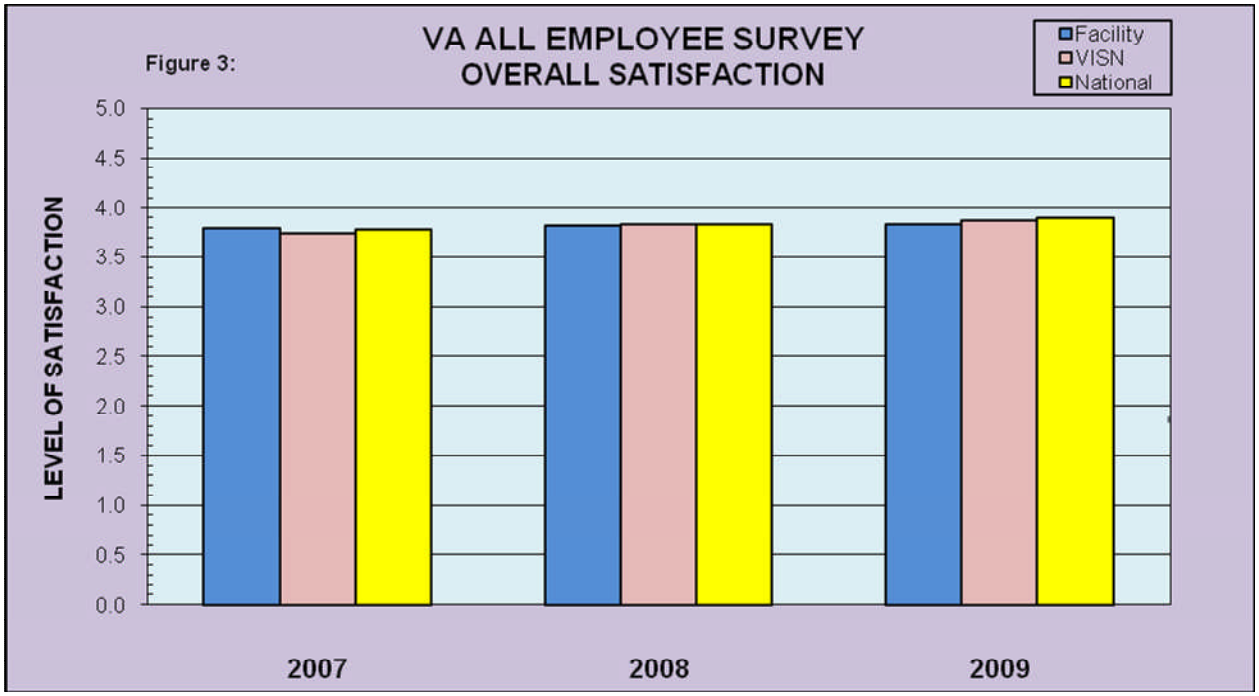
[15] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.





Employees are surveyed annually. Figure 3 on the next page shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:


VA ALL EMPLOYEE SURVEY
OVERALL SATISFACTION
Facility
VISN
National
LEVEL OF SATISFACTION
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2007
2008
2009

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 22, 2010

From: Director, VA Southeast Network (10N7)

Subject: **Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina**

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

Director, Management Review Service (10B5)

1. Please note the responses from Columbia, SC from the recommendations of the OIG CAP survey of January 11–15, 2010.

2. Please contact Ms. Jean Hooper, Director, QM at the Columbia, SC VAMC at 803-695-4000 x 6437.

(original signed by:)
Lawrence A. Biro

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 22, 2010

From: Director, William Jennings Bryan Dorn VA Medical Center (544/00)

Subject: **Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina**

To: Director, VA Southeast Network (10N7)

1. We have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the William Jennings Bryan Dorn VA Medical Center. We concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

(original signed by:)
Patricia Pittman

Medical Center Director/CEO

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 Medical Center Director requires that all RME competencies are evaluated annually and documented.

Concur

Target Date: March 29, 2010

All Nurse Managers, Service Line Leaders, as well as the Chief of SPD will certify annually to the RME Committee that all staff members assigned to their units who clean/disinfect non-critical and semi-critical RME have been evaluated through annual competency review. SPD staff members who clean and sterilize critical RME are continuing ongoing training and competency review as new items are identified and SOPs developed.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director implements corrective actions to ensure that negative air pressure is maintained in the SPD reprocessing area.

Concur

Target Date: June 18, 2010

Interim Plan: Installing additional exhaust to make the area negative pressure.

Long Range Plan: To meet the VA design criteria; funds are obligated for a study to correct the negative pressure, humidity levels and air handler. The consultant will begin the study the week of March 22, 2010. Based on the recommendations, a design and construction contract will be submitted. The scope of the construction project is unknown until completion of the study. The plan is obligate design funds in FY 2011 and complete construction in 2012.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director implements corrective actions to ensure six air exchanges per hour in the GI reprocessing area.

Concur

Target Date: Completed

Interim Plan: This has been corrected. Eight air exchanges per hour have been achieved through adjustments in the air handling systems.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the appropriate humidity level is maintained in the SPD clean storage area.

Concur

Target Date: September 17, 2010

Interim Plan: Installing a humidifier in the branch duct work supplying the SPD clean storage area, along with controls and alarms to control humidity.

Long Range Plan: To meet the VA design criteria; funds are obligated for a study to correct the negative pressure, humidity levels and air handler. The consultant will begin the study the week of March 22, 2010. Based on the recommendations, a design and construction contract will be submitted. The scope of the construction project is unknown until completion of the study. The plan is obligate design funds in FY 2011 and complete construction in 2012.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the medical records of patients undergoing flexible endoscopic procedures contain documentation of the RME serial number and the name of the provider who performed the procedure.

Concur

Target Date: Completed

The flexible endoscope serial number and provider name is entered into the electronic record using the EndoWorks program for GI procedures. An addendum is added to the procedure note for bronchoscopy, cyctoscopy, and ENT procedures.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires reporting of staff competency validation, SOP compliance, infection prevention and control monitoring, and risk management activities to an executive-level committee.

Concur

Target Date: April 6, 2010

An annual report beginning April 28, 2010, will be provided to the Health Systems Council denoting compliance with the following areas:

Unit/ Department	Inventory complete	PD's/Funct statements/ Perf standards Written	PD's/Funct statements/ Perf standard to all Employees	SOP's complete	Competencies complete

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires the PRC to document all required committee activities.

Concur

Target Date: Completed

Minutes format has been changed to ensure clear delineation of open action items that require follow up until completed.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires the collection of data on resuscitation events and outcomes to identify opportunities for improvement.

Concur

Target Date: Completed

Report submitted to Health Systems Council in January 2010 with subsequent quarterly reports to begin March 23, 2010.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires implementation of a tracking system to ensure that designated clinically active staff members comply with CPR certification requirements.

Concur

Target Date: Completed

Medical Staff Office tracks all licensed independent providers and Hospital Education tracks all remaining staff that required this AED, BCLS or ACLS training as defined by hospital policy. Reminder letters, signed by the Chief of Staff, are mailed to the employee and Service Chief when certifications are two months from expiration and again upon expiration. Proposed changes to hospital policy will allow for administrative action to occur should a clinically active employee not maintain AED, BCLS or ACLS certification. Number independent providers = 394 with all current;

18 scheduled in March for re-certification. Number clinical staff = 1416 with 1373 (96.6%) current.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires annual MRI safety education to be provided to appropriate staff.

Concur

Target Date: April 30, 2010

Training for Level 1 and Level 2 personnel is completed. Hospital Education Services will make future Level 1 and 2 training available through Synquest (electronic education program) which will enhance record-keeping of those trained.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires Zone 3 access to be physically restricted in accordance with TJC's guidance.

Concur

Target Date: April 9, 2010

A risk assessment is to be completed to identify the hazards related to installation of physical barrier yet allows stretcher access to Zone 3. Interim Plan: Zone 3 is not left unattended during operational hours.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires preventive maintenance on the MRI panic alarm to be conducted in accordance with contract requirements.

Concur

Target Date: completed

Preventive maintenance alarm check completed and records are maintained in Police Service. Record provides date of completion, status (operable or inoperable), and signature of individual completing the check.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires that staff monitor and evaluate patient transfers as part of the QM program.

Concur

Target Date: April 30, 2010

Interdisciplinary focus team revising current process to ensure completion of VA Form 10-2649A, "Inter-Facility Transfer Form," and VA Form 10-2649B, "Physician Certification and Patient Consent for Transfer Form," when a patient is transferred to another facility. The process change is to be completed by April 9 with staff education to be completed by April 23, 2010. 100% of transfers to another facility will be reviewed during the month of May with weekly feedback to service chiefs and providers of process improvement compliance. Quarterly reports to Health Systems Council will begin July 2010.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that all appropriate staff receive annual training on MH environmental hazards, as required.

Concur

Target Date: March 31, 2009

Education information has been distributed to Mental Health inpatient and outpatient nursing; psychology; provider; social work; vocational/occupational therapy staff; as well as engineering, environmental management, and dietary staff who come the Mental Health building at Dorn, with documentation maintained by the Suicide Prevention Program Coordinator until the program becomes available in LMS.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently document patient vaccine education, as required by VHA.

Concur

Target Date: July 30, 2010

Electronic note template for CLC Veterans is now consistent with documentation as demonstrated in the attachment. The first 10 vaccines administered in the CLC will be reviewed for compliance with providing patient education.

Recommendation 16. We recommended that the VISN Director ensure that the Medical Center Director requires that privileges are granted in accordance with VHA requirements.

Concur

Target Date: Completed

Modifications made to On-Ongoing Professional Practice Evaluation process to include numbers of high risk and/or low volume procedures to be reported in compliance with hospital policy to the Medical Executive Sub-Council. When a licensed independent practitioner has a change in type of appointment (i.e., from fee basis to staff) an On-Going Professional Practice Evaluation is completed in lieu of a Focused Professional Practice Evaluation due to no break in service.

Focused Professional Practice Evaluation process is initiated when a provider requests an increase in privileges. Weekly reports are presented in Clinical Supervisors meeting.

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