Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00371-157

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

April 18, 2012

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
CRC	colorectal cancer
ELSC	Executive Leadership Steering Committee
EOC	environment of care
facility	William Jennings Bryan Dorn VA Medical Center
FY	fiscal year
HSC	Health Systems Council
MH	mental health
MRI	magnetic resonance imaging
OIG	Office of Inspector General
PI	performance improvement
PRRC	Psychosocial Rehabilitation and Recovery Center
PUMA	physician utilization management advisor
QM	quality management
RME	reusable medical equipment
TBI	traumatic brain injury
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of February 13, 2012.

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

- Environment of Care
- Medication Management
- Psychosocial Rehabilitation and Recovery Centers

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that subordinate committees report data to the Executive Leadership Steering Committee; that the committee reviews and analyzes data, takes appropriate actions, and tracks actions to completion; and that committee membership includes the Patient Safety Manager. Require senior managers to discuss Inpatient Evaluation Center data and to document the discussion. Ensure the Peer Review Committee is notified when corrective actions are completed. Require the utilization management reviewer and the physician advisor to complete all required activities. Update the cardiopulmonary resuscitation policy, and review each resuscitation episode. Ensure committee minutes reflect analyses of medical record quality reviews, document actions, track actions to completion, and include evaluation of actions.

Polytrauma: Ensure all patients with positive traumatic brain injury screening results to have a comprehensive evaluation within the required timeframe. Maintain minimum staffing levels.

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe.

Coordination of Care: Consistently schedule follow-up appointments within the providers' recommended timeframes.

Moderate Sedation: Document timeouts in patients' medical records.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through February 13, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from

our prior CAP review of the facility (*Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* Report No. 10-00044-138, April 27, 2010). (See Appendix B for further details.) The facility had repeat findings in the area of QM.

During this review, we also presented crime awareness briefings for 368 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 296 responded. Survey results were shared 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.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	There was a senior-level committee/group responsible for QM/PI, and it included all required members.
X	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
X	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
X	If cases were referred to a PUMA for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
X	There was a CPR review policy and process that complied with selected requirements.
X	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed
	There was evidence at the senior management level that QM, patient safety, and systems redesign were integrated.
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in PI over the past 12 months.
X	Overall, the facility had a comprehensive, effective QM/PI program over the past 12 months.
X	The facility complied with any additional elements required by local policy.

QM/PI Committee Oversight. VHA requires that the facility's leadership committee (the ELSC) review and analyze data, take appropriate actions and track those actions for completion, and evaluate actions for effectiveness.[1] VHA also requires that ELSC committee membership include the Patient Safety Manager. Local policy requires that the HSC and Medical Staff Executive Committee report data to the ELSC. The HSC and Medical Staff Executive Committee did not report subordinate committee data to the ELSC. Therefore, the ELSC could not review and analyze data, take action, or track actions as necessary. Additionally, the Patient Safety Manager was not a member of the ELSC.

Inpatient Evaluation Data. VHA expects senior managers to discuss the data from the Inpatient Evaluation Center at a senior-level committee and to document the discussion in the meeting minutes.[2] There was no evidence over the past 12 months that senior managers had discussed the data at a senior-level committee.

Peer Review. VHA requires that the Peer Review Committee receive written notification upon completion of corrective actions for cases determined to be a Level 2 or Level 3.[3] We reviewed meeting minutes for the period June–November 2011 and identified 10 corrective actions that should have been completed. There was no evidence that any of these corrective actions were reported to the committee as completed. This was a repeat finding from the previous CAP review.

UM. VHA requires that staff who perform UM reviews participate in daily rounds, bed huddles, or interdisciplinary team meetings.[4] In addition, local policy requires referral of cases not meeting standardized UM criteria to the PUMA, who should consult with physicians, recommend changes in levels of care, and document decisions in the UM Review Report spreadsheet. The UM reviewer did not attend daily rounds, bed huddles, or interdisciplinary team meetings. We reviewed the UM Review Report spreadsheet for 10 cases reviewed from January 23–February 7, 2012, and found that the PUMA did not complete all the activities required by local policy. Documentation

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] Deputy of QM in VHA for Operations and Management, "Evaluation of Quality Management in VHA Facilities FY 2010," memorandum, February 23, 2011.
[3] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[4] VHA Directive 2010-021, *Utilization Management Program,* May 14, 2010.

reflects that the PUMA agreed with the UM reviewer's findings; however, the PUMA did not document any additional actions taken, such as changes in level of care.

Two weeks prior to our site visit, the facility identified deficiencies in UM processes and initiated corrective actions. However, not enough time had elapsed to determine whether the corrective actions were effective.

Resuscitation. VHA requires that local policy define responsibilities of the CPR Committee, which must include a review of each resuscitation episode to identify PI opportunities and implementation of corrective actions.[5] The facility's policy did not include the required elements. In addition, we reviewed Intensive Care Unit Sub-Council meeting minutes from May–September 2011 and found that the Sub-Council had not reviewed each resuscitation episode. This was a repeat finding from the previous CAP review.

Medical Record Review. VHA requires the facility's medical records committee to analyze results of medical record quality reviews, determine corrective actions, and ensure completion and evaluation of the effectiveness of actions.[6] We reviewed HSC (the designated medical records committee) meeting minutes for January–October 2011. The Health Information Manager had made recommendations based on the results of monthly medical record quality reviews in reports submitted to the HSC. However, the minutes did not reflect consistent review of the reports and did not document analysis or recommendations for corrective actions. In addition, when the HSC identified corrective actions, subsequent meeting minutes did not address the status of actions or evaluate them for effectiveness.

Recommendations

1. We recommended that processes be strengthened to ensure that subordinate committees report data to the ELSC.

2. We recommended that processes be strengthened to ensure that the ELSC reviews and analyzes data, takes appropriate actions, and tracks those actions to completion.

3. We recommended that the Patient Safety Manager be added as a member of the ELSC.

4. We recommended that senior managers discuss the data from the Inpatient Evaluation Center at a senior-level committee and document the discussion in the committee's meeting minutes.

5. We recommended that processes be strengthened to ensure that the Peer Review Committee is notified when corrective actions are completed.

[5] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.
[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

6. We recommended that processes be strengthened to ensure that the UM reviewer participates in daily rounds, bed huddles, or interdisciplinary team meetings and that the PUMA completes all required activities.

7. We recommended that the facility CPR policy include all VHA required elements and that processes be strengthened to ensure that each resuscitation episode is reviewed.

8. We recommended that processes be strengthened to ensure that HSC meeting minutes reflect analyses of medical record quality reviews, document recommended actions, track actions to completion, and include evaluation of the actions for effectiveness.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive TBI results, and training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Timely Evaluation. VHA requires that patients with positive TBI screening results have a comprehensive TBI evaluation within 30 days of the positive screening.[7] None of the nine[8] applicable medical records contained evidence that the patients were evaluated within 30 days.

Available Staffing. VHA requires that minimum staffing levels be maintained.[9] The facility did not meet the minimum staffing requirement as it did not have a rehabilitation nurse.

[7] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans,* March 8, 2010.
[8] One patient who screened positive for TBI could not be located for a comprehensive TBI evaluation.
[9] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Recommendations

9. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

10. We recommended that minimum staffing levels be maintained.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection–Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[10] One patient received diagnostic testing within the required timeframe. Six patients were offered colonoscopies but either refused the procedure or cancelled their appointments. Of the remaining 13 records, 6 patients who should have had diagnostic testing did not receive testing, and 7 patients who received diagnostic testing did not receive testing within the required timeframe.

Recommendation

11. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

[10] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of heart failure received adequate discharge planning and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of heart failure management key components.

We reviewed 24 heart failure patients' medical records and relevant facility policies, and we interviewed employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
X	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[11] Providers did not include recommendations for follow-up for two patients. Additionally, one patient had a recommended follow-up appointment timeframe, but the facility did not schedule the appointment as requested.

Recommendation

12. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the providers' recommended timeframes.

[11] VHA Handbook 1907.01.

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 medical records, and 7 training/competency records, and we interviewed key individuals. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
X	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Timeouts. VHA requires that timeouts be documented in patients' medical records.[12] Four patients' medical records did not have timeouts documented.

Recommendation

13. We recommended that processes be strengthened to ensure that timeouts are documented in patients' medical records.

[12] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures,* May 17, 2010.

Review Activities Without Recommendations

EOC

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

We inspected the emergency room; the primary care (Blue and Red), dental, eye, urology, polytrauma, and dermatology clinics; the rehabilitation medicine areas, including occupational and physical therapy and kinesiology; the medical, surgical, cardiac, and step-down intensive care units; the inpatient surgery, medicine, hospice, and MH units; the operating and recovery rooms; and the CLCs. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications are secured and properly stored, and medication safety practices are in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

Comments

The Acting VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 22–29, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[13]		
Type of Organization	Primary care, tertiary care, and long-term care medical center	
Complexity Level	1C	
VISN	7	
Community Based Outpatient Clinics	Anderson, SC Florence, SC Greenville, SC Rock Hill, SC Orangeburg, SC Spartanburg, SC Sumter, SC	
Veteran Population in Catchment Area	426,052	
Type and Number of Total Operating Beds: • **Hospital**	95 medical/surgical	
• **CLC/Nursing Home Care Unit**	75	
• **Other**	17 (inpatient MH)	
Medical School Affiliation(s)	University of South Carolina School of Medicine and College of Nursing South Carolina College of Pharmacy	
• **Number of Residents**	50 resident/fellow positions	
	Current FY through January 2012	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$359	$392
• **Medical Care Expenditures**	$123	$392
Total Medical Care Full-Time Employee Equivalents	1,865	1,833
Workload:		
• **Number of Station Level Unique Patients**	51,557	71,615
• **Inpatient Days of Care:**		
o **Acute Care**	11,026	31,717
o **CLC/Nursing Home Care Unit**	7,517	23,769
Hospital Discharges	1,695	5,128
Total Average Daily Census (including all bed types)	151	152
Cumulative Occupancy Rate (in percent)	65	69
Outpatient Visits	262,516	862,309

[13] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
RME		
1. Require that all RME competencies are evaluated annually and documented.	The competency compliance for FY 2011 was 95 percent. Training and competencies for 2012 are in process and include a Skills Fair.	N
2. Implement corrective actions to ensure that negative air pressure is maintained in the Sterile Processing and Distribution reprocessing area.	A construction project to correct deficiencies is in process. In the interim, an alternate site for sterile processing and decontamination is being used.	N
3. Implement corrective actions to ensure six air exchanges per hour in the gastroenterology reprocessing area.	We are now in compliance since installation of medivators, which require 10 air exchanges per hour.	N
4. Require that the appropriate humidity level is maintained in the Sterile Processing and Distribution clean storage area.	A construction project to correct deficiencies is in process. A temporary primary sterile storage area has been designated where the temperature and humidity levels are maintained.	N
5. Require 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.	All gastroenterology scope serial numbers and provider names are documented in Endoworks and loaded into the Computerized Patient Record System for procedures completed in October and November 2011.	N
6. Require reporting of staff competency validation, standard operating procedure compliance, infection prevention and control monitoring, and risk management activities to an executive-level committee.	Quarterly reports containing all required elements are provided to the HSC through an RME Committee Report.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
QM		
7. Require the Peer Review Committee to document all required committee activities.	Peer Review Committee minutes reflect recommendations, follow-up responsibility, and action completion.	Y (see page 4)
8. Require the collection of data on resuscitation events and outcomes to identify opportunities for improvement.	We comply with data collection, analysis, identification of opportunities for improvement, and reporting requirements.	Y (see page 5)
9. Require implementation of a tracking system to ensure that designated clinically active staff members comply with CPR certification requirements.	CPR expiration dates for designated clinically active staff members are tracked along with automatic notifications to staff prior to expiration.	N
MRI Safety		
10. Require annual MRI safety education to be provided to appropriate staff.	Annual MRI safety education was provided to all appropriate staff, including radiology technicians, police officers, and housekeepers.	N
11. Require Zone 3 access to be physically restricted in accordance with Joint Commission guidance.	A limited access door has been installed in accordance with Joint Commission guidance.	N
12. Require preventive maintenance on the MRI panic alarm to be conducted in accordance with contract requirements.	FY 2011 and FY 2012 to date monthly compliance is 100 percent.	N
Coordination of Care		
13. Require that staff monitor and evaluate patient transfers as part of the QM program.	Patient transfers are monitored as part of the QM program. Documentation issues are being addressed through education and improved processes.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
EOC		
14. Require that all appropriate staff receive annual training on MH environmental hazards, as required.	All appropriate staff have received training on MH environmental hazards for FY 2012.	N
Medication Management		
15. Require that clinicians consistently document patient vaccine education, as required by VHA.	CLC patient records for the first 10 vaccines administered in FY 2012 reflect documentation of patient vaccine education.	N
Physician Credentialing and Privileging		
16. Require that privileges are granted in accordance with VHA requirements.	We continue to monitor. The compliance rates were 64 percent for focused and 70 percent for ongoing provider evaluations in FY 2012.	N

VHA Satisfaction Surveys

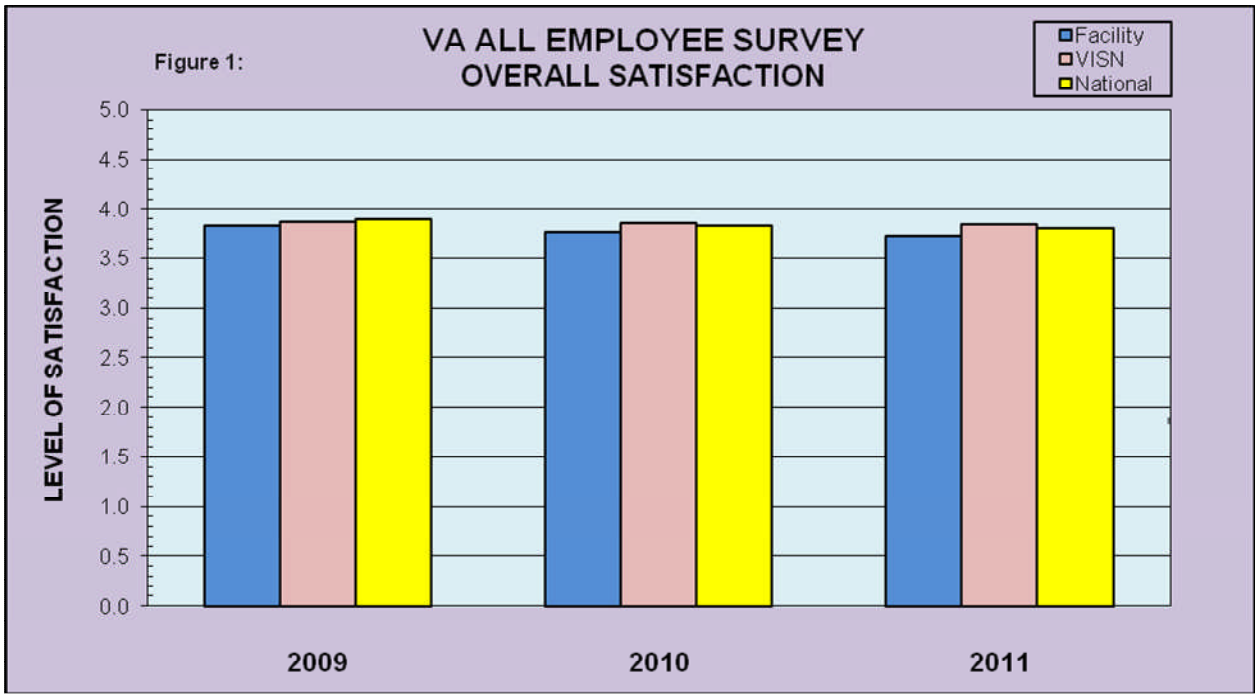
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	57.3	58.0	58.7	53.9	48.7	52.6
VISN	63.3	62.4	52.1	51.1	50.9	51.6
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[14] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[15]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	15.7	9.3	10.6	19.1	22.5	18.9
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

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

[15] 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.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 29, 2011

From: Acting Director, VA Southeast Network, VISN 7 (10N7)

Subject: **CAP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC**

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

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

1. I concur with the recommendations and actions taken by the Medical Center Director, Columbia, SC.

2. If you have any questions, please contact me at (678) 924-5701.

(original signed by)
James A. Clark, MPA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 03-26-2012

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

Subject: **CAP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC**

To: Acting Director, VA Southeast Network (10N7)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG CAP Review conducted at the William Jennings Bryan Dorn VA Medical Center.

2. Please find the attached response to each recommendation provided in the report for your review. I concur with the recommendations and we have already initiated corrective actions.

3. If you have any questions regarding the response to the recommendations in the report, please feel free to call me at (803) 695-7980.

(original signed by)
Rebecca Wiley

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 subordinate committees report data to the ELSC.

Concur

Target date for completion: July 31, 2012

A leadership workgroup will critically review the existing Committee/Council structure and minutes to identify vulnerabilities in the communication process. Structure, function, and minutes from other Medical Center's will be included in the analysis for comparison and identification of improvement opportunities. A new Medical Center Memorandum (MCM) will be developed that will clearly define a standardized format for meeting minutes and reporting of data through the Committee structure up to ELSC. Data discussed will be evaluated for variations in performance and stability. All committees will use appropriate statistical methods to present data trends (charts, tables, graphs, etc.)

Recommendation 2. We recommended that processes be strengthened to ensure that the ELSC reviews and analyzes data, takes appropriate actions, and tracks those actions to completion.

Concur

Target date for completion: May 31, 2012

A leadership workgroup will critically review the existing Committee/Council structure and minutes to identify vulnerabilities in the communication process. Structure, function, and minutes from other Medical Center's will be included in the analysis for comparison and identification of improvement opportunities. The Director will establish a new executive level quality management committee to provide oversight of quality data related to VHA performance measures, Joint Commission ORYX accountability measures, patient satisfaction data, business and financial measures, Deputy Under Secretary for Health measures, significant patient safety activities, Utilization Management trends, Risk Management data trends, and actions required in response to internal and external reviews. A new MCM will be developed that will clearly define a standardized format for meeting minutes and reporting of data through the Committee structure up to ELSC. Data discussed will be evaluated for variations in performance and stability. All committees will use appropriate statistical methods to present data trends (charts, tables, graphs, etc.). A committee tracking log will be used to track open items through closure.

Recommendation 3. We recommended that the Patient Safety Manager be added as a member of the ELSC.

Concur

Target date for completion: Addendum to MCM 544-702, ELSC will be completed by April 13, 2012.

On March 16, 2012 the ELSC approved the addition of Patient Safety Manager to this committee. An addendum will be added to MCM 544-702 ELSC adding the Patient Safety Manager as a member of this committee.

Recommendation 4. We recommended that senior managers discuss the data from the Inpatient Evaluation Center at a senior-level committee and document the discussion in the committee's meeting minutes.

Concur

Target date for completion: Quarterly reporting to ELSC will begin April 30, 2012. Quarterly reporting to new executive level quality management committee will begin July 31, 2012.

The Inpatient Evaluation Center (IPEC) data has been sent to and reviewed by senior leadership as a standing practice. IPEC data related to hospital acquired infections (MRSA, central line associated blood stream infections, catheter associated urinary tract infections, and ventilator associated pneumonia) has always been reported to the Infection Control Sub-Council and then onto the Health Systems Council which is chaired by the Chief of Staff and the Associate Director for Patient Care and Nursing Services/Nurse Executive. To strengthen this process, the IPEC data (LINKs reports) will be added as a quarterly report to the new executive level quality management committee once established. In the interim, this report will be presented to ELSC for review, analysis, comparative evaluation of outcomes against internal/external benchmarks, and recommendations for changes as needed to improve patient outcomes.

Recommendation 5. We recommended that processes be strengthened to ensure that the Peer Review Committee is notified when corrective actions are completed.

Concur

Target date for completion: This action was completed effective March 19, 2012.

The Peer Review Committee (PRC) recommendations for system and process actions are tracked until closure in the minutes. "Follow Up- Action Items" is a recurring agenda topic that includes; date, trigger/reason for review, initial review findings, provider response, PRC discussion, action, target date, responsible person, and status. Although this has been the process in place, the action item(s) were closed once assigned to the responsible service chief or supervisor. This process has been

strengthened by tracking Level 2 and Level 3 actions until notification is received from the service chief/supervisor that the all actions are complete.

Recommendation 6. We recommended that processes be strengthened to ensure the UM reviewer participates in daily rounds, bed huddles, or interdisciplinary team meetings and that the PUMA completes all required activities.

Concur

Target date for completion: The PUMA education requirements were completed March 22, 2012. Integration of PUMAs into the UM Program through required activities will be implemented by March 30, 2012. Monitoring for PUMA compliance with required activities will occur April 1 through September 30, 2012.

Upon review of VHA Directive 2010-021 Utilization Management Program, the facility notes the recommendation for the UM reviewer is to participate in daily rounds, bed huddles, and/or Interdisciplinary Team meetings as appropriate, but not mandatory, as indicated in Recommendation 6. To this end, the UM Coordinator has strengthened collaboration and communication with nursing staff, social workers, transfer coordinators, providers, discharge planners, and other services/departments as appropriate to ensure a proactive organizational approach to daily patient flow activities. The UM reviewer has an existing process to interact efficiently and effectively with the interdisciplinary and bed flow teams when continued stay reviews become problematic.

The six (6) PUMAs have completed all required training as of March 22, 2012. The UM Program will be strengthened through the use of NUMI Tracker, a multiuser database that allows PUMAs to evaluate each admission and continued stay review that did not meet criteria. The review in NUMI Tracker includes the reason for not meeting InterQual criteria and recommended level of care. The PUMA will document a response and action taken. NUMI tracker will be used for analyzing and trending reviews not meeting criteria and PUMA activity. Monitoring will begin April 1, 2012 and will continue through September 30, 2012. Continuation of measuring compliance will be re-evaluated after the initial review period.

Recommendation 7. We recommended that the facility CPR policy include all VHA required elements and that processes be strengthened to ensure that each resuscitation episode is reviewed.

Concur

Target date for completion: MCM 544-313 Cardiopulmonary Resuscitation (CPR) and Code 5 Team Policy will be revised by May 1, 2012. Effective March 20, 2012, an aggregated CPR outcomes data report for the ICU Sub-Council was implemented.

MCM 544-313 CPR and Code 5 Team Policy will be revised to include all required elements. The ICU Sub-Council reviews each resuscitation episode and its outcomes ensuring that resuscitation services are consistent with current literature and research. The process will be strengthened by the implementation of an aggregated data report to

analyze, track, trend, and evaluate resuscitation processes against internal/external comparative benchmarks and review outcomes to determine opportunities for improvement. This report will be submitted each month to the ICU Sub-Council for review, discussion, and recommendations in corrective actions for implementation when indicated.

Recommendation 8. We recommended that processes be strengthened to ensure that Health Systems Council (HSC) meeting minutes reflect analyses of medical record quality reviews, document recommended actions, track actions to completion, and include evaluation of the actions for effectiveness.

Concur

Target date for completion: July 31, 2012

The Health Information Management Service (HIMS) conducts medical record quality audits monthly and aggregates findings into a quarterly report that includes data analysis, trends, corrective actions, evaluation of outcomes related to the corrective actions, and recommendations for improvement. This report is provided quarterly to HSC. To strengthen the existing process, a leadership workgroup will critically review the existing structure, function, and minutes of the HSC to identify vulnerabilities in the communication process. A new MCM will be developed that will clearly define a standardized format for meeting minutes and reporting of data of all committees and sub-councils to include HSC. Included in this MCM will be the process and expectation for reporting and documenting in the minutes actions, tracking of actions to completion, the inclusion of evaluation of actions for effectiveness, and the process for reporting unresolved or other significant issues up through the Committee structure to ELSC. Data discussed will be evaluated for variations in performance and stability. All committees will use appropriate statistical methods to present data trends (charts, tables, graphs, etc.) All committees will use appropriate statistical methods to present data trends (charts, tables, graphs, etc.). A committee tracking log will be used to track open items through closure.

Recommendation 9. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

Concur

Target date for completion: July 31, 2012

The Polytrauma Team will review existing practices and implement processes that further prioritize TBI Second Level Evaluations over new and follow-up TBI appointments. Approval is pending for two evening clinic profiles to accommodate the Veterans that have limited time during the day to attend clinic due to work and school. With the restructuring of the clinic schedule and prioritization of TBI Second Level Evaluations, the Polytrauma Team will be able to add three (3) additional slots a week to the existing clinic schedule.

Recommendation 10. We recommended that minimum staffing levels be maintained.

Concur

Target date for completion: July 3, 2012

The Polytrauma Service has submitted a request to Executive Leadership through the Planning Council for the hiring of the required 1 FTEE Rehabilitation Nurse and Occupational Therapist.

Recommendation 11. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: September 30, 2012

To ensure patients with positive CRC screening test results receive diagnostic testing within the 60 day required timeframe, we have established a proactive approach to strengthen our internal processes:

1. Active recruitment for nursing, clerical and provider staffing for full capacity.
2. Establishment of a Primary Care FOBT Program Coordinator to review Heme (+) results and ensure appropriate and timely scheduling.
3. Filling the vacant RN GI Case Manager position to effectively case manage colonoscopies and upper endoscopies and provide follow-up with community partners to ensure continuity of care and address any issues as needed.

Additionally, we have developed an alternative process for intermediate and high-intermediate risk patients to be seen with community partners to ensure patients are seen quickly and receive quality care in an expeditious manner.

Recommendation 12. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the providers recommended timeframes.

Concur

Target date for completion: April 30, 2012

Cardiology and the Primary Care (PC) Service have collaboratively reviewed the existing process and identified the inpatient discharge process of these patients as a specific area for improvement. Currently, no standard process is used to schedule a follow-up appointment for patients (followed by PC) with heart failure upon discharge. The current discharge note has prompts to schedule follow-up appointments. The clinical applications coordinators will revise the discharge note/template to include a CHF diagnosis tab that will trigger the appointment ordering process. The appointment

will be scheduled within the providers recommended timeframe and prior to the discharge of the Veteran. The appropriate CHF/PC provider will be added as cosigners on the discharge summary to ensure this information is communicated. All patients receive a 2 day post-discharge call from the PC care manager. Review of follow up appointments will be discussed with the patients at this time.

Recommendation 13. We recommended that processes be strengthened to ensure that timeouts are documented in patients' medical records.

Concur

Target date for completion: Secondary education of staff will be completed by May 10, 2012. Increased, focused monitoring began February 24, 2012 and will continue through May 30, 2012.

All providers have been re-educated on the timeout process to include documentation in the medical record. On May 7, 2012 the National Center for Patient Safety will provide Medical Staff Team Training for Non-OR providers related to the Universal Protocol and invasive procedures (with and without moderate sedation) performed outside of the OR. This training will include special emphasis on conducting and documenting the pre-procedure verification and timeout. Prior to February 2012, documentation review of nonOR procedures was conducted on a random selection of approximately 5% of the cases; data was aggregated and reported quarterly to the Non-OR Invasive Procedure Sub-Council (NOIPSC). On February 24, 2012, monthly retrospective documentation reviews were initiated on a minimum of 15% of cases in those areas determined to be high risk for noncompliance based on the findings from the recent OIG CAP site visit. Effective April 1, 2012, aggregated data reports with analysis, evaluation, trending, and benchmarking will be reported to the NOIPSC for review and recommendations to improve compliance when indicated.

A retrospective chart review of timeout documentation conducted on 30 episodes of care from February 24–March 12, 2012, revealed documentation compliance of 100%. Intensive monitoring will continue until sustained compliance is greater than 90% in all areas. Continuation of the increased targeted monitoring for compliance will be re-evaluated after the initial review period.

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