Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00621-23

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

November 10, 2015

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CLC	community living center
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Charles George VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SAIL	Strategic Analytics for Improvement and Learning
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of September 14, 2015.

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

- Coordination of Care
- Computed Tomography Radiation Monitoring
- Surgical Complexity

The facility's accomplishments were an improvement initiative for admission and patient flow processes, a 5-Star quality rating, and a number 1 ranking for patient satisfaction out of 128 VA medical centers.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure licensed independent practitioners' folders do not contain non-allowed information. Require the Surgical Work Group to meet monthly. Include most services in the review of electronic health record quality.

Environment of Care: Conduct fire drills in all health care occupancy buildings with the frequency required. Ensure negative air pressure systems on the surgical intensive care unit are functional. Require locked mental health unit stationary and portable panic alarm testing to include documentation of VA Police response times.

Medication Management: Complete monthly medication storage area inspections, implement corrective actions for issues identified during inspections, and track the actions until fully resolved. Revise the policy for safe use of automated dispensing machines to include training and minimum competency requirements for nursing employee users.

Advance Directives: Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives. Hold the discussions requested, and document them.

Emergency Airway Management: Ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice. Revise the local policy to include that all designated non-anesthesia providers receive training in emergency airway management. Complete a root cause analysis for the emergency airway management event.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–32, for the full text of the Directors' comments.) We consider recommendations 1, 10, 11, and 13 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

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

The review covered facility operations for FY 2014 and FY 2015 through September 14, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Charles George VA Medical Center, Asheville, North Carolina,* Report No. 13-00276-135, March 18, 2013).

During this review, we presented crime awareness briefings for 351 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. We distributed an electronic survey to all facility employees and received 425 responses. We shared summarized results with facility managers.

In this report, we made recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Be a Bed Ahead Initiative

Facility nursing employees led an initiative to improve the facility's admission process. The goal was to improve patient flow through better communication between the Emergency Department and the inpatient units accepting patients for admission. The initiative streamlined the admission process and resulted in: (1) an 18 percent reduction in the average time to admission from the Emergency Department, (2) an 87 percent reduction in employee phone calls made to admit a patient, (3) improved communication and understanding among nursing employees, (4) improved working relationships across departments, and (5) increased customer satisfaction. Nursing employees are now able to readily respond to patient admission needs, which has improved patient satisfaction.

Quality of Care and Patient Satisfaction

The facility is a 5-Star facility in SAIL[1] and in the top 5 percent of performers among all VA facilities. The facility's journey to a 5-Star rating was accomplished by engaging all employees, encouraging data transparency, and using data to not only improve performance but to make data-driven decisions. In addition to the other outstanding SAIL results, as of October 2014, the facility was ranked number 1 out of 128 VA medical centers in the nation for patient satisfaction.

[1] The SAIL Value Model is a system for summarizing hospital system performance within VHA.

Results and Recommendations

QM

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

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Two of the 10 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met 10 times over the past 12 months.	**2.** We recommended that the Surgical Work Group meet monthly.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • The review of EHR quality did not include quarterly reports from Surgery or Primary Care Services.	**3.** We recommended that the facility include most services in the review of electronic health record quality.
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the surgical intensive care, 4W medicine/cardiology/oncology, and locked MH units; the Emergency Department; CLC 1 and 2; primary care clinic 3; and the oncology clinic. We also inspected the perimeter of the 4E oncology unit construction project. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Past 3 quarters of fire drill documentation for health care occupancy buildings reviewed: • All applicable buildings did not have at least one fire drill per shift per quarter.	**4.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• Neither of the two negative air pressure systems in the surgical intensive care unit airborne infection isolation rooms was functional.	**5.** We recommended that facility managers ensure negative air pressure systems on the surgical intensive care unit are functional and monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VA National Center for Patient Safety MH EOC Checklist reviewed, which requires testing of panic alarms, including VA Police response times, on a periodic basis at a frequency determined by the facility. Panic alarm testing documentation for August 2015 reviewed: • Although employees conducted stationary and portable panic alarm testing on the locked MH unit, there was no documentation of VA Police response time.	**6.** We recommended that facility managers ensure that locked mental health unit stationary and portable panic alarm testing includes documentation of VA Police response times.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for Construction Safety	Findings	Recommendations
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected CLC 2, the Emergency Department, and the medical intensive care and 5W medicine/surgical units, and for these areas, we reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
X	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.	• From March through August 2015, the medical intensive care unit and CLC 2 had one or more missed monthly medication storage area inspection. • The facility did not consistently implement corrective actions for issues identified during monthly medication storage area inspections in any of the four areas.	**7.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance. **8.** We recommended that the facility consistently implement corrective actions for issues identified during monthly medication storage area inspections and that facility managers monitor the corrective actions until fully resolved.
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for nursing employee users.	**9.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include training and minimum competency requirements for nursing employee users and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for eight CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 49 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 49 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		.
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Seven of the 48 applicable EHRs did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs. • Five of the seven applicable EHRs did not contain documentation that employees held the AD discussions requested.	**10.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance. **11.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 11 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

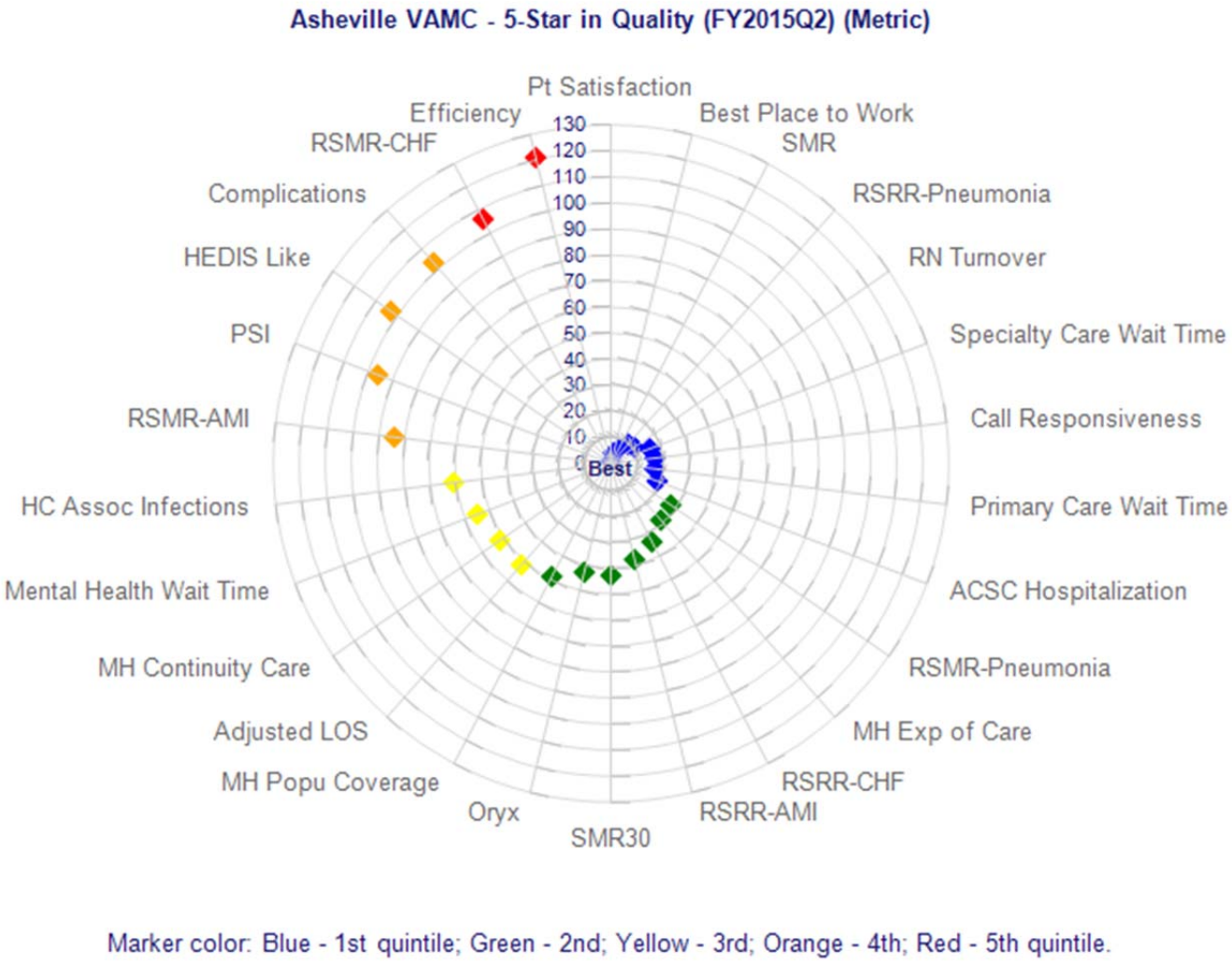
NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• Ten of the 11 clinicians did not have reassessments for continued EAM competency completed at the time of renewal of privileges or scope of practice.	**12.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy on out of operating room airway management reviewed, which requires specific EAM training for designated non-anesthesia providers and completion of a root cause analysis if a clinician without EAM training performs an intubation procedure. • The facility deemed by policy that some non-anesthesia physicians were qualified for EAM without requiring completion of competency training. • One incident occurred where a provider who had not completed requirements for training in EAM completed an intubation procedure.	**13.** We recommended that the facility revise the local policy to include that all designated non-anesthesia providers receive training in emergency airway management. **14.** We recommended that the facility complete a root cause analysis for the event to determine why this vulnerability existed and initiate appropriate system improvements.

Facility Profile (Asheville/637) FY 2015 through August 2015[2]	
Type of Organization	Tertiary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$307.3
Number of:	
• **Unique Patients**	37,783
• **Outpatient Visits**	418,327
• **Unique Employees**[3]	1,523
Type and Number of Operating Beds:	
• **Hospital**	83
• **CLC**	73
• **MH**	18
Average Daily Census:	
• **Hospital**	63
• **CLC**	51
• **MH**	15
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Franklin/637GA Rutherfordton/637GB
VISN Number	6

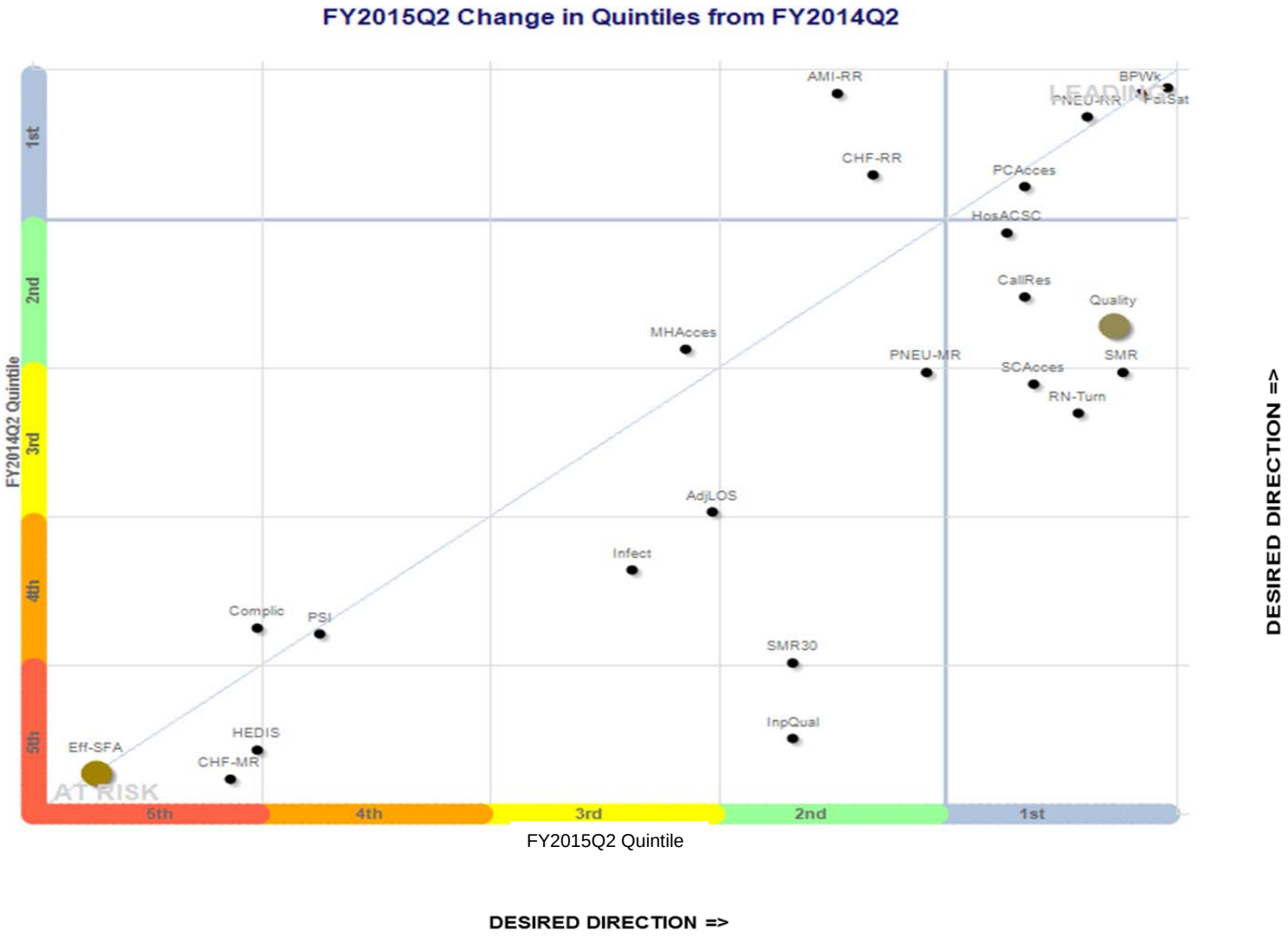
[2] All data is for FY 2015 through August 2015 except where noted.
[3] Unique employees involved in direct medical care (cost center 8200).

SAIL[4]



[4] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: October 14, 2015

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

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

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached, please find the Charles George VA Medical Center response to the report from the Office of Inspector General Combined Assessment Program.

2. I have reviewed and concur with the completed response.

3. I appreciate the Office of Inspector General's efforts to ensure high quality care is provided to the Veterans at the Charles George VA VAMC.

4. For further inquiries, please contact Lisa Shear, QMO at (919) 956-5541.

(original signed by:)
Daniel F. Hoffman, FACHE
Network Director, VISN 6

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 14, 2015

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

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

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

1. Thank you for the opportunity to review the report from the Office of Inspector General Combined Assessment Program of the Charles George VA Medical Center, Asheville, NC.

2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report. Below please find the facility concurrence and response to the findings from the review.

3. If you have any questions or need further information, please contact Robin James, Chief Quality Management at (828) 298-7911 Ext. 5596.

(original signed by:)
Cynthia Breyfogle, FACHE
Medical Center Director, Charles George VA Medical Center

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 the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: Completed September 25, 2015

Facility response: By September 25, 2015 the credentialing staff completed a 100% review of the 397 two part Credentialing & Privileging (C&P) folders, and removed all non-allowed ACLS and moderate sedation certificates from the folders. C&P staff implemented a process to ensure that none of the C&P folders presented to PSB contain any of the non-allowed information.

Recommendation 2. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: December 2015

Facility response: Effective December 2014 there was a change in leadership to include the Chief of Surgery Service and Administrative Officer (AO). Beginning with the December 2014 meeting, the Surgical Workgroup (SWG) has consistently met on a monthly basis and will continue to do so. By December 2015 SWG meeting, there will be 12 months of minutes.

Recommendation 3. We recommended that the facility include most services in the review of electronic health record quality.

Concur

Target date for completion: December 2015

Facility response: In July 2015, the Health Information Management (HIMS) Chief, the Chair of the Medical Records Committee (MRC) and Chief of Staff (COS) began ensuring that the monthly medical record reviews were being completed by Primary Care and Surgical Services. Since that date review results for these two services were included in the MRC committee's reporting cycle on a monthly basis to assure consistent reviewing and reporting. Since July 2015 the MRC committee minutes reflect the reporting for these two services.

Recommendation 4. We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

Concur

Target date for completion: March 2016

Facility response: The Safety Office revised the fire drill process on October 1, 2015 to ensure that all applicable buildings have at least one fire drill per shift per quarter. Fire drills are reported in the Life Safety management report which includes the date, time, and outcome of each fire drill. By the end of March 2016, there will be six months of fire drill compliance data.

Recommendation 5. We recommended that facility managers ensure negative air pressure systems on the surgical intensive care unit are functional and monitor compliance.

Concur

Target date for completion: March 2016

Facility response: As of September 25, 2015, all of the negative air pressure systems were functional. The third party vendor, Wynergy, will test all negative air pressure systems on a monthly basis. Beginning October 2015, the quarterly negative air pressure system testing will be reported to the Infection Control Committee (ICC), and by the end of March 2016 there will be six months of negative air pressure compliance data.

Recommendation 6. We recommended that facility managers ensure that locked mental health unit stationary and portable panic alarm testing includes documentation of VA Police response times.

Concur

Target date for completion: March 2016

Facility response: The VA Police Service implemented new standards and updated the Duress Alarm Standard Operating Procedure on September 18, 2015, requiring monthly response drills for the stationary and portable duress alarms in the locked Mental Health Unit. Since this date a duress response drill is being conducted monthly by each of our four shifts, two shifts checking the portable and two shifts checking the stationary alarms. A Duress Response Critique Report is completed at the time the drill is conducted, and is reviewed by VA Police leadership. Each report indicates the date, time and location of the alarm tested, responding officers and response times. A monthly aggregation of reporting these checks was initiated in September 2015 and will be routinely reported to the Administrative Executive Council (AEC).

Recommendation 7. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: April 2016

Facility response: By September 21, 2015 all areas where storage may occur were reviewed and validated by Nursing and Pharmacy Services, and a final list was approved. The inspection assignment process was examined and modified to ensure timely inspections. Beginning October 15, 2015 the completion of inspections will be verified 5–7 days prior to the end of each month. Monthly medication inspection records will be reviewed and aggregated to reflect all medication storage areas, and reported to Medical Staff Executive Council (MSEC).

Recommendation 8. We recommended that the facility consistently implement corrective actions for issues identified during monthly medication storage area inspections and that facility managers monitor the corrective actions until fully resolved.

Concur

Target date for completion: April 2016

Facility response: The week of September 18, 2015 staff was educated on the checklist of subjects to review and how to document corrective actions for issues identified during monthly medication storage area inspections. Since the education, actions are being implemented immediately after each inspection. Monthly medication inspection records reflecting corrective actions will be reviewed. These data will be aggregated and reported to MSEC.

Recommendation 9. We recommended that the facility revise the policy for safe use of automated dispensing machines to include training and minimum competency requirements for nursing employee users and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2016

Facility response: The local MCM 637-119-17 Automated Medication Dispensing Cabinets (Omnicell) was reviewed and revised to reflect that Pharmacy, Nursing, and Anesthesia staff will receive training and competency verification on the proper use of the automated medication dispensing cabinets. We will monitor for compliance with training until 90 percent compliance is reached. The policy update was signed and implemented October 7, 2015.

Recommendation 10. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: Completed October 23, 2015

Facility response: A reminder dialogue was implemented on December 2, 2014, assuring that the documentation of screening for admitted patients includes asking if the Veteran wanted to have an Advance Directive (AD) discussion. Additionally, by that date, revisions were made to the language in the screening tool to clarify the documentation to reflect that all patients receive AD information and are offered discussion with a Social Worker.

A 100 percent record review for the time frame of December 2, 2014 to February 28, 2015 was completed by the Inpatient Social Work Supervisor, looking at the post implementation of the clinical reminder and the revised tool for documentation of the discussion. Of the 294 records reviewed, 292 (99 percent) patients had the screening and documentation reflecting asking if they wanted an AD discussion.

Recommendation 11. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: Completed October 23, 2015

Facility response: December 2, 2014, a reminder dialogue was implemented and revisions were made to the language in the screening tool to clarify that the documentation reflected the offer of a discussion with a Social Worker. If the patient requested an AD discussion, a consult was generated to the Social Worker.

A sample of admissions from May 1, 2015 to August 30, 2015 was randomly selected and a retrospective review by the inpatient Social Work Supervisor was completed. Of the 68 medical records reviewed, the documentation reflected that 7 patients requested a discussion during screening and 7 patients (100 percent) had the discussion with the correct note title used.

Recommendation 12. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.

Concur

Target date for completion: January 2016

Facility response: In July of 2014 a robust training and competency program was implemented by the Chief of Respiratory Therapy and Chief of Anesthesiology. Additionally the team established a robust monitoring dashboard that has since been maintained up to date. The dash board enables supervisory staff to ensure that all clinicians maintain current completion of the required TMS mandatory modules I and II, SIM recertification completion within the 10–11 month window since the last SIM recertification, and a mandatory OR rotation shortly after completion of the SIM recertification. The robust process ensures that 100 percent of clinicians have maintained current competencies and competency folders, since July 2014. Ongoing compliance is monitored.

Recommendation 13. We recommended that the facility revise the local policy to include that all designated non-anesthesia providers receive training in emergency airway management.

Concur

Target date for completion: Completed September 23, 2015

Facility response: The local MCM 637-11-105 Out Of Operating Room Airway Management was reviewed and revised to include language stating that all designated non-anesthesia providers receive training in emergency airway management. The MCM was revised by a second bulletin, dated September 23, 2015.

Recommendation 14. We recommended that the facility complete a root cause analysis for the event to determine why this vulnerability existed and initiate appropriate system improvements.

Concur

Target date for completion: October 31, 2015

Facility response: A possible vulnerability was identified when a provider who had not completed requirements for EAM training performed an intubation. The facility policy MCM 637-11-105 Out of Operating Room Airway Management was revised by the first bulletin dated July 31, 2015 to include language requiring an RCA be conducted when any non-certified provider performed an intubation. An RCA was conducted and concluded on September 17, 2015. Recommendations for systems improvements will be implemented by October 31, 2015.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at **www.va.gov/oig**.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] References used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.