Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00872-52

Healthcare Inspection

Follow-Up Evaluation of Quality of Care, Management Controls, and Administrative Operations William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

December 15, 2014

Washington, DC 20420

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Executive Summary

At the request of Members of the House and Senate Committees on Veterans' Affairs, the VA Office of Inspector General Office of Healthcare Inspections conducted an evaluation of conditions identified in the OIG report *Quality of Care, Management Controls, and Administrative Operations*, OIG Report No. 13-00872-71, issued February 6, 2014 (the initial report), at the William Jennings Bryan (WJB) Dorn VA Medical Center (facility), Columbia, SC. The purpose of this follow-up review was to determine whether identified conditions have abated, continued unchanged, or worsened and whether OIG's recommendations were implemented.

In the initial hotline report, we noted that critical leadership positions were filled by a series of "acting" and temporary managers over a period of several years, which contributed to past delays in correcting identified deficiencies. A permanent Chief of Staff and Medical Center Director were installed in January and April 2014 respectively, which has accelerated the facility's progress in addressing deficient conditions. However, many of the problems outlined in our initial hotline report still existed, in whole or in part, at the time of our July follow-up visit. We found that the facility had implemented corrective actions in response to the 12 recommendations in our initial report, yet the effectiveness of those actions varied widely. While corrective actions resolved the deficient conditions associated with operating room and reusable medical equipment issues, other actions were less successful, as they were not always implemented timely, were not complete, or were not sustained. In addition, during this visit, we found improper storage of patient information, medical and surgical supplies, medications, grafts, and patches.

A stable and unified leadership team is essential to the accomplishment of organizational goals. Now that many key positions have been filled, the leadership team is making progress on communicating the facility's goals and priorities, addressing deficiencies and weaknesses, and setting the "tone" for performance improvement.

We agree with closure of 2 recommendations from the initial report and will continue to follow up on the remaining 10 recommendations. We made one additional recommendation. We recommended that the Facility Director ensure that patient information, medical and surgical supplies, medications, grafts, and patches are stored properly throughout the facility and that compliance be monitored to ensure sustained improvement.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report and recommendation. (See Appendixes A and B, pages 7–10, for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

At the request of Members of the House and Senate Committees on Veterans' Affairs, the VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation of conditions identified in the OIG report *Quality of Care, Management Controls, and Administrative Operations,* OIG Report No. 13-00872-71, issued February 6, 2014 (the initial report), at the William Jennings Bryan (WJB) Dorn VA Medical Center (facility), Columbia, SC. The purpose was to determine whether identified conditions have abated, continued unchanged, or worsened and whether OIG's recommendations were implemented.

Background

The facility provides a broad range of inpatient and outpatient medical, surgical, mental health, and long-term care services. It has 95 operating hospital beds and 75 community living center beds. Outpatient care is also provided at seven community based outpatient clinics located in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The facility serves a veteran population of about 410,000 throughout South Carolina and is part of Veterans Integrated Service Network (VISN) 7.

For the initial hotline report, the OIG visited the facility on six occasions between February and June 2013 to review allegations concerning quality of care, clinical oversight, management controls, and administrative operations in the Surgery Service, as well as facility-level deficiencies in the Infection Control (IC), Quality Management (QM), and Peer Review programs. We substantiated many of the allegations and made 12 recommendations for improvement.

Scope and Methodology

We conducted our follow-up visit to the facility July 28–31, 2014. Our primary focus was to determine whether actions taken in response to the initial hotline report were implemented and effective and to evaluate whether conditions had improved. We interviewed employees; reviewed QM and administrative records, relevant facility and national policies and reports, standard operating procedures (SOPs) and manufacturers' instructions (MI), training records, employee competencies, staffing plans, and oversight committee minutes; and, we toured the Supply Processing Service (SPS) and other clinical areas.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

In our initial report, we substantiated many of the allegations. We also identified inadequate processes, poor data analysis and reporting, and a weak oversight and accountability structure. The facility implemented corrective actions in response to our recommendations, and several of the conditions were improved or resolved at the time of our July follow-up visit. However, some actions were not timely, effective, complete, or sustained.

In our initial hotline report, we also noted that critical leadership positions were filled by a series of temporary managers over a period of several years, which contributed to delays in correcting identified deficiencies. A stable and unified leadership team is essential to the accomplishment of organizational goals. Many key positions have been filled, which has accelerated the facility's progress in resolving the deficiencies, communicating the facility's goals and priorities, and setting the "tone" for performance improvement.

The following table provides the initial hotline report recommendations, status of the conditions, improvements/corrections made, and improvements still needed.

Table 1. Follow-Up on Initial Hotline Report Recommendations

INITIAL HOTLINE REPORT RECOMMENDATIONS	JULY 2014 STATUS	FOLLOW-UP EVALUATION FINDINGS
LEADERSHIP		
1. The VISN Director takes action to ensure more permanent, stable leadership in key positions.	Condition Improved	*Improvements/Corrections:* The following leadership positions have been filled in 2014: • Chief of Staff (January 26) • Medical Center Director (April 20) • Chief of Medicine (August 11) *Still needed:* Chiefs for Surgery and Gastroenterology.
Issue 1: SURGICAL SERVICE		
2. The Facility Director ensures that morbidity outliers are discussed and analyzed and that corrective actions are taken as indicated.	Condition Improved	*Improvements/Corrections:* Surgical Work Group and Medical Executive Board (MEB) minutes reflect that the National Surgery Office and Veterans Administration Surgical Quality Improvement Program (VASQIP) reports were presented. *Still needed:* Meeting minutes need to reflect morbidity outliers including: • Identification, discussion, and analysis of the trends, patterns, and planned action(s).
3. The Facility Director ensures that residents and staff discontinue use of logbooks and utilize	Condition Improved	*Improvements/Corrections:* The Surgical Service SharePoint to track and schedule surgical cases was fully implemented in May 2014. The Privacy

approved electronic methods to track and schedule surgical cases.		Officer participated in the Environment of Care rounds and reported that logbooks were not being used. *Still needed:* While touring the surgical resident reading room, we found a paper notebook containing patient information. In addition, we found: • Documents, radiographic images, and compact disks containing patient health information. • Storage of current and expired medical/surgical supplies, medications (Lidocaine), and Artegrafts and Dura-Guard Dural Repair patches[1] not stored in a temperature and humidity-controlled environment. When notified, the facility took the following steps: • Reviewed items containing patient information to determine appropriate action. • Collected, reviewed, and discarded the improperly stored supplies, medications, grafts, and patches. • Educated current residents on proper storage and handling of supplies, medications, and patient information; will be included in future resident orientation. • Enhanced Environment of Care and Privacy rounds, and the ongoing monitoring and cleaning of the resident reading room. We are making a new recommendation related to monitoring for sustained improvement.
4. The Facility Director ensures adequate staffing and processes to minimize Operating Room (OR) delays and meet patient care needs.	Complete	*Improvements/Corrections:* The facility: • Improved the speed of hire[2] measure to 89 percent, which exceeds the Veterans Health Administration (VHA) target of 80 percent. • Approved the Outpatient Surgical Staffing Plan and Registered Nurse Case Manager Model for the outpatient surgical clinic, with a proposed increase of three licensed practical nurses.

[1] Surgical patches.
[2] Elapsed calendar time beginning with the date Human Resources receives an actionable request to file a position and ending with the date the candidate receives a tentative job offer.

		Anesthesia Service: • Hired two certified registered nurse anesthetists (one additional position awaiting selection by the hiring official). • Hired two anesthesiologists. • Is tracking delays and wait times through implementing first case of the day pre-operative briefings and utilization of the OR scheduling process.
Issue 2: INFECTION CONTROL		
5. The Facility Director ensures that IC surveillance data is analyzed and trended and that IC Sub-Council minutes include required elements and reflect preventive and corrective measures.	Condition Improved	*Improvements/Corrections:* The IC Sub-Council Committee meeting minutes provided analysis and trending of IC surveillance data, identified corrective actions, and identified follow through to completion. Required data elements for VASQIP cases were reported as required. *Still Needed:* Required data elements for non-VASQIP cases were not reported as required.
Issue 3: SUPPLY PROCESSING SERVICE		
6. The Facility Director ensures compliance with VHA guidance regarding identification, reporting, and follow-up of Reusable Medical Equipment (RME) reprocessing issues and that RME committee minutes reflect these and other required elements.	Complete	*Improvements/Corrections:* The RME Committee meeting minutes provide detailed information that included problem identification through action completion. Surgical and SPS staff noted improvement in the cleanliness and sterility of instruments delivered to and returned from the OR. When issues are identified, they are addressed, and concerns are often discussed at daily huddles.
7. The Facility Director improves SPS processes to ensure staff are trained and competent in relevant RME reprocessing activities and that competencies, manufacturer instructions, and standard operating procedures are consistent.	Condition Improved	*Improvements/Corrections:* Corrective actions were implemented to partially resolve the identified issues. *Still Needed:* • Surgical nursing staff competencies for pre-cleaning were not completed annually, as required. • OR staff training was not conducted until 5 months after publication of a new pre-cleaning policy, and competencies were not completed until 11 months after publication. • OR staff documented that they "demonstrated" competency; however, the staff only verbalized the process without demonstration.[3]

[3] VHA Directive 2009-004 states that "Competency is the assurance that an individual has received the appropriate training and has demonstrated an achieved skill level required to independently and appropriately perform an assigned task or responsibility."

		• Appropriate SPS staff had current training and competency forms on file; however, competency was not demonstrated as required. SPS staff only verbalized the training steps to the RME Educator following training sessions. • The RME Committee is updating and modifying SOPs and competencies to align with MIs; however, the updates and modifications will not occur until the MIs change or the SOP is due for renewal; some are not due for renewal until December 2014 and February 2015.
Issue 5: QM OPERATIONS AND ACTIVITIES		
8. The Facility Director ensures that QM oversight and reporting structures are fully integrated, comprehensive, and functional.	Condition Improved	*Improvements/Corrections:* Some oversight QM activities had improved as procedures were modified. *Still needed:* Progress has been slow, and continued improvements are necessary as evidenced by the following: • A modified QM policy had been developed but not yet approved. • The newly appointed Facility Director and Chief of Staff verbalized knowledge that the current QM program and policy, as well as the supporting committees and processes, required restructuring in order to provide the required oversight.
9. The Facility Director ensures oversight and subordinate committee minutes include required elements and reflect data analysis, conclusions, action tracking and follow-up, and outcome measurement.	Condition Improved	*Improvements/Corrections:* Minor modifications have been made to oversight and subordinate committee minutes, and some policies have been revised to align with VHA and other requirements. *Still Needed: C*ontinued modifications of the oversight and subordinate committee policies and structures need to align with the overall facility QM and VHA policies.
10. The Facility Director ensures compliance with patient safety program reporting and evaluation policies and ensures that reportable close calls are clearly defined in policy.	Condition Improved	*Improvements/Corrections:* The local Patient Safety Reporting Program policy is in alignment with national requirements, including defining events that would constitute a “close call” and appropriate processes for reporting. The 2013 Patient Safety Program annual report was presented to the MEB as required by local policy. *Still needed:* Staff were not consistently reporting identified close calls to the Patient Safety Manager. In addition, staff we interviewed were inconsistent with the definition and reporting requirements for close calls.

Issue 6: PEER REVIEW		
11. The Facility Director ensures compliance with VHA policies on identification and reporting of cases for peer review, including use of the Occurrence Screening package.	Condition Improved	*Improvements/Corrections:* The facility hired peer review staff, reprogrammed the Occurrence Screening package, and implemented a process where VASQIP mortality reports are considered for possible peer review. *Still needed:* Cases identified in the surgical Mortality and Morbidity Conferences were not consistently being referred for peer review consideration.
12. The Facility Director ensures the Peer Review Committee complies in a timely manner with VHA guidelines regarding discussion, analysis, tracking, and follow-up of final Peer Review Committee decisions.	Condition Improved	*Improvements/Corrections:* The Peer Review Committee and MEB meeting minutes reflect many of the peer review reporting elements required by VHA, and recent (July 2014) minutes reflect improved data analysis and suggested actions. *Still needed:* Minutes did not reflect follow-up of identified systems issues.

Conclusions

We found that the facility implemented corrective actions in response to the 12 recommendations in our initial hotline report; however, the effectiveness of those actions varied widely. While corrective actions partially resolved the deficient conditions associated with OR and RME issues, other actions were not implemented timely, were not complete, or were not sustained. As a result, many of the problems outlined in the initial hotline report still existed, in whole or in part, at the time of our July 2014 follow-up visit. In addition, we found improper storage of patient information, medical and surgical supplies, medications, grafts, and patches during this visit.

We noted that since many of the key positions have been filled, the leadership team has been making progress on resolving the deficiencies, communicating the facility's goals and priorities, and enhancing performance improvement efforts.

We consider recommendations 4 and 6 from the initial report to be closed. We determined that the remaining 10 recommendations still needed improvement, and we made 1 additional recommendation in this report.

Recommendation

1. We recommended that the Facility Director ensure that patient information, medical and surgical supplies, medications, grafts, and patches are stored properly throughout the facility and that compliance be monitored to ensure sustained improvement.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: October 27, 2014

From: Director, VA Southeast Network (10N7)

Subject: **Draft Report**—Healthcare Inspection—Follow-Up Evaluation of Quality of Care, Management Controls, and Administrative Operations, WJB Dorn VA Medical Center, Columbia, SC

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

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

1. Recommendation: The VISN Director takes action to ensure more permanent, stable leadership in key positions: Still Need Chiefs for Surgery and Gastroenterology:

   a. The Columbia VA has successfully completed recruitment for the Chief of Surgery who has an EDD date of November 2, 2014.

   b. The Chief of GI position has been posted for a second time. The current recruitment will close on November 30, 2014.

2. Thank you for the opportunity to provide an update to the status of this report.

(original signed by:)
Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 23, 2014

From: Director, WJB Dorn VA Medical Center, Columbia, SC (544/00)

Subject: **Draft Report**— Healthcare Inspection—Follow-Up Evaluation of Quality of Care, Management Controls, and Administrative Operations, WJB Dorn VA Medical Center, Columbia, SC

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and provide comments to this report.

2. I concur with recommendations presented by the Office of Healthcare Inspections and present you with corrective actions as noted in the comments section.

3. If you have any questions or need further information, please contact Bridget Schausten (803) 776-4000, x7731.

(original signed by:)
Timothy B. McMurry
Medical Center Director

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensure that patient information, medical and surgical supplies, medications, grafts, and patches are stored properly throughout the facility and monitor to ensure sustained improvement.

Concur

Target date for completion: November 3, 2014

Facility response:

Dorn hired a new Privacy Officer on October 6, 2014 that works closely with the Chief Information Officer, the Records Manager, and the Information Security Officer to ensure that personal health information is secured throughout the facility. This Privacy Officer is also responsible for education to heighten employee awareness of the importance of protecting highly sensitive information. On October 9, 2014 the Privacy Officer began attending staff meetings in order to provide education on the importance of protecting patient's privacy. This information is also shared in new employee orientation, employee forums, and through rounding.

The medical and surgical resident room was relocated on October 16, 2014 to minimize unnecessary storage of privacy information and supplies. All staff is required to take annual mandatory trainings in VA's Talent Management System for both Information Security and Privacy/HIPPA. Residents are also required to take the training as a component of the VHA Office of Academic Affiliations approved VHA Resident Orientation curriculum. The next resident rotation begins November 3, 2014. Additional education on required storage of supplies/medications, SPS items, and RME has been added to the facility resident orientation curriculum.

Environment of Care (EOC) Rounds are performed weekly and focus their efforts on ensuring that EOC accreditation standards are met throughout the facility. This includes checking for unsecured patient information, and appropriate storage of supplies, medications, grafts, and patches throughout the facility. The Assistant Director leads weekly EOC rounds with the facility EOC Rounds Coordinator. The core Environment of Care Rounds Team consists of representatives from Environmental Management, Nursing, Engineering, Safety, Patient Safety, Inventory Management and Supplies, Infection Control, Police and Security, Privacy and Information Security. This team began using new tablet computer technology consistent with VHA direction in August 2014, which has standardized and automated the rounds process and communications with the services assigned for

corrective action. EOC Rounds findings and corrective actions are tracked monthly in the Environment of Care Board.

To strengthen the process, the Environment of Care tracker was amended to specifically list action items for the medical and surgical resident rooms across the facility.

The Privacy Officer is a core member of the Environment of Care Rounds Team. The Privacy Officer will make her own monthly rounds and inspections including medical and surgical resident rooms throughout the facility during Fiscal Year 2015. The first inspection occurred October 22, 2014. There were no findings in the medical and surgical resident room and the residents were able to articulate privacy regulations. The Privacy Officer will track all action items found on her rounds until completion.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Toni Woodard, BS, Project Leader Victoria Coates, LICSW, MBA Sheyla Desir, RN, MSN Joanne Wasko, LCSW Robert Yang, MD

Appendix D

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