Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02191-274

Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center Charleston, South Carolina

September 6, 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
CBOC	community based outpatient clinic
CLC	community living center
CRC	colorectal cancer
EHR	electronic health record
EMS	Environmental Management Service
EOC	environment of care
facility	Ralph H. Johnson VA Medical Center
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TMH	telemental health
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center, Charleston, 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 July 9, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following activities:

- Coordination of Care
- Medication Management
- Mental Health Treatment Continuity
- Nurse Staffing
- Quality Management

The facility's reported accomplishments were an expansion of telemental health services across the Veterans Integrated Service Network and fluorescent gel monitoring to improve terminal cleaning and promote infection control.

Recommendations: We made recommendations in the following five activities:

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of diagnostic test and biopsy results within the required timeframe, and document notification.

Environment of Care: Require that dental lasers are included in inventory and evaluated annually and that dental staff complete required annual laser safety training. Ensure the spinal cord injury outpatient clinic nurse receives population-specific training.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Point-of-Care Testing: Ensure glucose point-of-care testing manuals are readily available in all testing areas.

Polytrauma: Maintain minimum polytrauma staffing levels. Develop a polytrauma program policy that complies with all applicable accrediting organization and Veterans Health Administration requirements.

Comments

The Interim 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 10 activities:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- 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 July 6, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center, Charleston, South Carolina,* Report No. 10-03091-88, February 14, 2011).

During this review, we presented crime awareness briefings for 248 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 205 responded. We shared survey results 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.

Reported Accomplishments

TMH

The facility's MH service line provides extensive TMH services to veterans across VISN 7. TMH is delivered via a "hub and spoke" model, where the facility (the hub) provides medication management and evidence-based psychotherapy to CBOC or other VISN 7 patients (the spokes). Because many of the CBOCs and other VISN 7 medical facilities are located in rural areas with limited ability to recruit MH professionals, the availability of TMH improves access to MH services and decreases travel time for patients. In FY 2011, the facility provided more than 7,500 patient encounters via TMH.

"High-Touch" Area Cleaning and Monitoring

EMS uses fluorescent gel monitoring to improve the quality of terminal cleaning and promote infection control. The Centers for Disease Control and Prevention recommends monitoring of 17 objects that are frequently touched and are most likely to transmit disease if not cleaned properly. EMS managers discreetly place gel marks that are invisible to the naked eye in inpatient rooms on the 17 high-touch objects. After terminal cleaning, EMS managers use a fluorescent light to determine whether the high-touch objects have been effectively cleaned. Training is provided to housekeepers on deficient items. Baseline scores showed that only 34 percent of the terminal cleanings were effective; however, through education and ongoing monitoring, the facility has achieved a terminal cleaning effectiveness rate of 90 percent.

Results
Review Activities With Recommendations

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 the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	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.[1] Three of the 14 patients who received diagnostic testing did not receive that testing within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[2] Two of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[3] Of the seven patients who had biopsies, four EHRs did not contain documented evidence of timely notification.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[3] VHA Directive 2007-004.

Recommendations

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

2. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

3. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

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 department and CLC; the primary care, podiatry, orthopedic, SCI, and dental clinics; and the inpatient medical, surgical, MH, and intensive care units. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
X	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
X	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP 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.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	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.

Dental Clinic Laser Safety and Training. Local policy requires that the Laser Safety Officer conduct annual evaluations of areas where lasers are being used, that all lasers be listed on the laser inventory, and that dental clinic employees who use or assist with laser procedures complete annual laser safety training. The dental clinic laser area had not been assessed annually, and the laser was not on the inventory. We reviewed five employee training records and determined that annual laser safety training was not conducted.

SCI Training. VHA requires that employees who work with SCI patients in outpatient clinics receive training specific to that population.[4] The SCI outpatient clinic nurse's training record did not contain documentation of SCI-related training.

Recommendations

4. We recommended that processes be strengthened to ensure that dental lasers are included in the inventory and evaluated annually and that dental staff complete required annual laser safety training.

5. We recommended that the SCI outpatient clinic nurse receive population-specific training.

[4] VHA Handbook 1176.01, *Spinal Cord Injury and Disorders (SCI/D) System of Care,* February 28, 2011.

Moderate Sedation

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

We reviewed relevant documents, 19 EHRs, and 73 training/competency records, and we interviewed key employees. 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.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	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.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a moderate sedation procedure and that patients be re-evaluated for any changes immediately before the procedure.[5] We found that 13 EHRs did not include all required elements of pre-sedation assessment documentation, such as airway assessment, review of alcohol or substance use or abuse, or assessment of risk.

Recommendation

6. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[5] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
X	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Program Management. VHA requires that test methods and instruments have clearly written manuals available in each testing area.[6] Manuals were not readily available in two patient care areas where glucose POCT was performed.

Recommendation

7. We recommended that glucose POCT manuals be readily available in all testing areas.

[6] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

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 EHRs of patients with positive traumatic brain injury screening results, 10 EHRs of polytrauma clinic patients, and 7 training records, and we interviewed key employees. The areas marked as non-compliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	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-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
X	The facility complied with any additional elements required by VHA policy.

Available Staffing. VHA requires that minimum staffing levels be maintained.[7] The facility did not meet the minimum staffing requirements for a designated part-time rehabilitation nurse, speech-language pathologist, physical therapist, and occupational therapist.

Facility Policy. VHA requires facilities to develop local policies for the polytrauma program.[8] The facility did not have a policy, and as a result, processes related to polytrauma care, services, staff training, and local responsibilities and expectations were not defined.

[7] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.
[8] VHA Directive 2009-028.

Recommendations

8. We recommended that minimum polytrauma staffing levels be maintained.

9. We recommended that the facility develop a polytrauma program policy that complies with all applicable accrediting organization and VHA requirements.

Review Activities Without Recommendations

Coordination of Care

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

We reviewed 15 HF patients' EHRs and relevant documents, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[9] therapy with methadone and buprenorphine and the handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[9] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 26 training files, and we interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for acute care unit 4BS for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

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 complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	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.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor 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.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	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.
	There was an EHR 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.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed (continued)
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Comments

The Interim VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–26, for the full text of the Directors' comments.) We consider Recommendations 4 and 7 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[10]		
Type of Organization	Tertiary care teaching hospital	
Complexity Level	1c	
VISN	7	
CBOCs	Beaufort, SC Goose Creek, SC Hinesville, GA Myrtle Beach, SC Savannah, GA	
Veteran Population in Catchment Area	53,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	98	
• **CLC/Nursing Home Care Unit**	28	
• **Other**	0	
Medical School Affiliation(s)	Medical University of South Carolina	
• **Number of Residents**	82	
	Current FY (through February 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$309.3	$295.4
• **Medical Care Expenditures**	$132.3	$295.4
Total Medical Care Full-Time Employee Equivalents	1,670.8	1,558.9
Workload:		
• **Number of Station Level Unique Patients**	43,464	53,663
• **Inpatient Days of Care:**		
o **Acute Care**	9,248	24,440
o **CLC/Nursing Home Care Unit**	2,943	6,265
Hospital Discharges	2,224	2,129
Total Average Daily Census (including all bed types)	61	67
Cumulative Occupancy Rate (in percent)	63.5	66.7
Outpatient Visits	281,278	654,595

[10] All data provided by facility management.

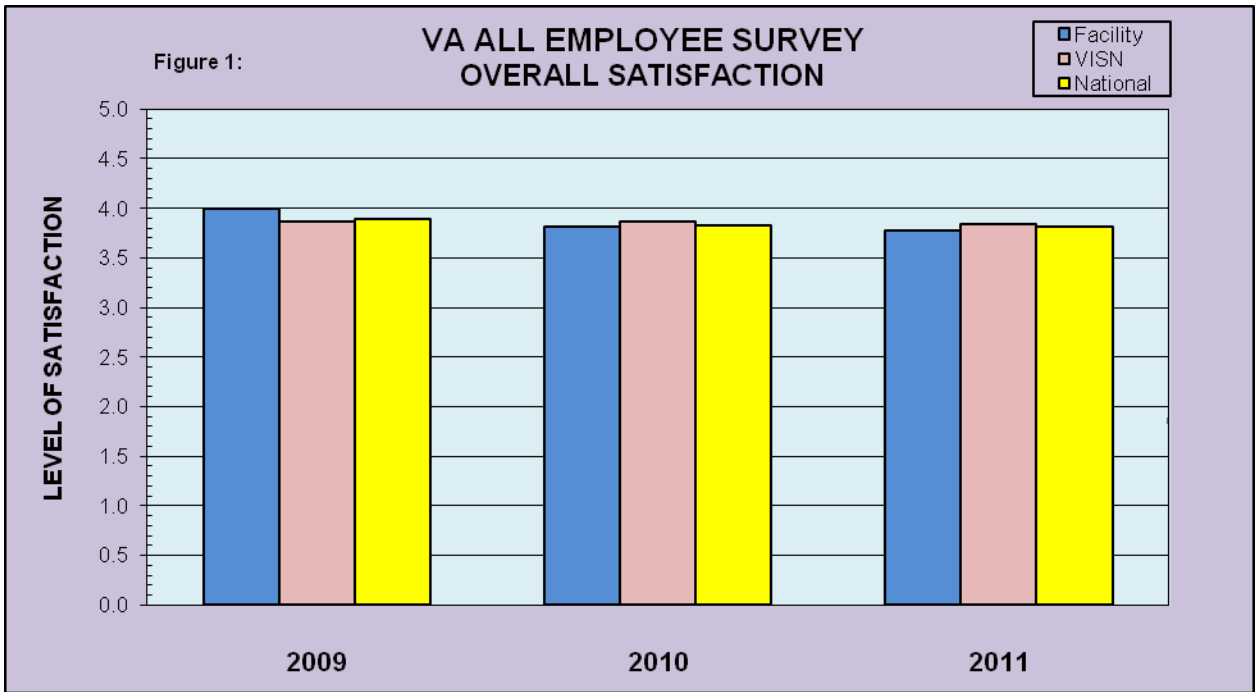
VHA Satisfaction Surveys

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 for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	68.2	62.0	53.9	52.0	52.3	53.2
VISN	62.4	63.3	50.9	51.6	51.8	51.3
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[11] 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, 2008, and June 30, 2011.[12]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.4	10.6	13.7	19.4	23.5	19.4
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[11] 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 HF 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.

[12] 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.

Appendix C

Interim VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 17, 2012

From: Interim Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Ralph H. Johnson VA Medical Center, Charleston, SC**

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

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

1. I fully concur with the Medical Center Director's recommendations and action plans for this review.

(original signed by:)
James A. Clark, MPA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2012

From: Director, Ralph H. Johnson VAMC (534/00)

Subject: **CAP Review of the Ralph H. Johnson VA Medical Center, Charleston, SC**

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

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Ralph H. Johnson VA Medical Center. There were nine (9) findings and recommendations.

2. I concurred with all of the recommendations, and we have completed or are in the process of completing the actions to resolve the issues.

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

(original signed by:)
CAROLYN L. ADAMS

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 patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: Process to be implemented NLT September 4, 2012.

Facility response.

GI will monitor the FOBT positive patients for the presence of appropriate referrals and/or documentation. GI will notify the appropriate provider when documentation is not present within 14 days of the FOBT results and track these monthly by provider for compliance. GI consults for diagnostic colonoscopy will be reviewed and managed by the nurse manager or designee after approval for colonoscopy by the GI attending. The nurse manager will ensure that these patients have their colonoscopy scheduled within 30 days date unless the patient elects otherwise, in which case that will be documented.

GI will monitor the timeliness of diagnostic testing after a positive screen to validate completion within 60 days. The C4 Colorectal Cancer monitoring tool will be utilized to track the information. The results will be reported on a monthly basis to the Clinical Executive Board until 90% compliance is achieved and then quarterly thereafter for FY 13.

Recommendation 2. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Process to be implemented NLT September 4, 2012.

Facility response.

Sending notification letters within 14 days is currently part of the process, and GI staff will be reminded of the requirement. New GI Fellows will be oriented to the process during their first week on duty. Random audits of colonoscopy patients will be conducted to be sure that the biopsy letters have been sent within 14 days of notification of the results. The C4 Colorectal Cancer monitoring tool will be utilized to track the information. The results will be reported on a monthly basis to the Clinical

Executive Board until 90% compliance is achieved and then quarterly thereafter for FY 13.

Recommendation 3. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Process to be implemented NLT September 4, 2012.

Facility response.

GI will orient new fellows to the Onc Watch "Biopsy Notification letter " at the beginning of their rotation each month, and document that training. This training will be at 100% participation and ongoing.

GI will conduct random audits of 10% of colonoscopy patients to be sure that the biopsy letters have been sent within 14 days of notification of the results. These audits will be conducted in the same month that the colonoscopy was done, so that the fellow who did the procedure is still here to receive feedback about the presence or absence of the biopsy letter. The results will be reported on a monthly basis to the Clinical Executive Board until 90% compliance is achieved and then quarterly thereafter for FY 13.

Recommendation 4. We recommended that processes be strengthened to ensure that dental lasers are included in the inventory and evaluated annually and that dental staff complete required annual laser safety training.

Concur

Target date for completion: Completed.

Facility response.

The evaluation for FY 2012 has been completed. The Dental Laser is now in the medical equipment inventory and will be included in the Preventive Maintenance Inspection Program to ensure evaluations occur annually from this point forward. All dental providers and dental technicians have completed the Laser Safety training in TMS.

Recommendation 5. We recommended that the SCI outpatient clinic nurse receive population-specific training.

Concur

Target date for completion: September 30, 2012

Facility response.

The SCI outpatient is scheduled to attend SCI training at the Augusta VAMC at the end of September.

Recommendation 6. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: Process changes have been completed.
Target date for full compliance: October 30, 2012

Facility response.

The Procedure Note templates used by the physicians in the moderate sedation areas have been modified to include all required elements and the fields have been made mandatory. This will guide providers to complete the required documentation in CPRS.

Documentation requirements for the nursing procedure record have been reviewed with the nursing staff in the respective areas. Quality management will conduct audits to validate compliance. Reports will be given at the Invasive Procedures Review Committee monthly until a compliance rate of ≥90% is achieved then reports will move to quarterly through at least FY 2013.

Recommendation 7. We recommended that glucose POCT manuals be readily available in all testing areas.

Concur

Target date for completion: Completed

Facility response.

Electronic versions of the POCT manuals have been placed on the common staff T-drive for read access by all employees. Hard copy manuals (for contingency planning) are also available on the wards and in the laboratory.

Recommendation 8. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: September 30, 2012

Facility response.

A center policy is currently being developed to ensure compliance with all applicable accrediting organization and VHA requirements. The policy will delineate minimum staffing levels that are appropriate for the size and scope of our Polytrauma Program.

Recommendation 9. We recommended that the facility develop a polytrauma program policy that complies with all applicable accrediting organization and VHA requirements.

Concur

Target date for completion: September 30, 2012

Facility response.

A center policy is currently being developed to ensure compliance with all applicable accrediting organization and VHA requirements.

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