Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-02314-39

Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia

January 7, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CS	controlled substances
CSC	Construction Safety Committee
EHR	electronic health record
EOC	environment of care
facility	Carl Vinson VA Medical Center
FY	fiscal year
HPC	hospice and palliative care
IC	infection control
IPEC	Inpatient Evaluation Center
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
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 9, 2013.

Review Results: The review covered eight activities.

Recommendations: We made recommendations in all eight of the following activities:

Quality Management: Include the facility Director as a member of the senior-level committee responsible for quality management and performance improvement. Ensure that senior leaders routinely discuss the facility's Inpatient Evaluation Center data and that the discussions are documented in the minutes of a senior-level committee. Revise the local observation bed policy to include that each observation patient must have a focused goal for the period of observation and that each admission must have a clinical condition that is appropriate for observation. Ensure the peer review, observation bed, cardiopulmonary resuscitation, electronic health record quality, and blood usage review processes meet applicable requirements. Require that representatives from Surgery, Medicine, and Anesthesia Services attend Blood Usage Committee meetings. Ensure Medical Executive Committee and Quality Leadership Team minutes reflect discussion of improvement opportunities and track actions to completion for Inpatient Evaluation Center data and the copy and paste function. Conduct a full evaluation of quality management processes to determine whether improvements are needed to ensure a comprehensive and effective program that monitors all required components.

Environment of Care: Ensure vents in patient care areas are clean. Require reusable medical equipment standard operating procedures and manufacturers' instructions to be consistent.

Medication Management – Controlled Substances Inspections: Ensure controlled substances inspectors receive annual updates or refresher training. Conduct monthly inspections of all non-pharmacy areas with controlled substances and pharmacy areas, and include all required elements in inspections.

Coordination of Care – Hospice and Palliative Care: Ensure all non-hospice and palliative care clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management: Establish an interprofessional pressure ulcer committee that includes a wound care specialist. Analyze pressure ulcer data, and report it to facility executive leadership. Perform and document a complete skin assessment on all patients within 24 hours of admission and a patient skin inspection and risk scale at discharge. Accurately document location, stage, risk scale score, and

date pressure ulcer acquired for all patients with pressure ulcers. Consistently perform and document daily risk scales and daily skin inspections for patients at risk for or with pressure ulcers. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers. Ensure designated employees receive training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to accurately document findings.

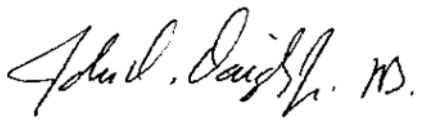
Nurse Staffing: Ensure all facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Construction Safety: Conduct and review infection control and tuberculosis risk assessments prior to construction project initiation. Ensure all members of the Construction Safety Committee participate in construction site inspections. Require documentation of site inspections to include the time of the inspection and names of those who participated. Conduct infection surveillance activities related to construction projects, and document this in Infection Control Committee minutes. Ensure Construction Safety Committee minutes contain documentation of any unsafe conditions identified in daily inspections. Require that contractors receive Occupational Safety and Health Administration Construction Safety training prior to project initiation and that designated employees receive initial and ongoing construction safety training.

Mental Health Residential Rehabilitation Treatment Program: Conduct and document monthly self-inspections. Perform and document daily bed checks and weekly contraband inspections. Ensure written agreements acknowledging resident responsibility for medication security are in place. Require that the units' main points of entry have keyless entry systems. Implement written processes to address behavioral health and medical emergencies, and ensure employees are aware of the actions to be taken.

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 22–35, for the full text of the Directors' comments.) We consider recommendations 1, 4, and 26 closed. We will follow up on the planned actions for the open recommendations until they are completed.



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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 – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety
- MH RRTP

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 2012 and FY 2013 through September 12, 2013, and was done 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 Carl Vinson VA Medical Center, Dublin, Georgia,* Report No. 10-00045-207, July 26, 2010). We made repeat recommendations in EOC and QM.

During this review, we presented crime awareness briefings for 309 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 114 responded. We shared summarized 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.

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 complied with selected requirements within its QM program.[1]

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

NC	Areas Reviewed	Findings
X	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	• The facility Director was not a member of the senior-level committee.
X	There was evidence that IPEC data was discussed by senior managers.	Twelve months of Medical Executive Committee meeting minutes reviewed: • There was no evidence that IPEC data was discussed.
X	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	• The facility did not provide documented evidence of compliance in the timeframe needed to fully evaluate this area.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
X	Local policy for the use of observation beds complied with selected requirements.	The facility's policy did not include that: • Observation patients must have a focused goal for the period of observation. • Each patient admitted must have a clinical condition that is appropriate for observation.
X	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	• The facility did not provide documented evidence of compliance in the timeframe needed to fully evaluate this area.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
X	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	• The facility did not provide documented evidence of compliance in the timeframe needed to fully evaluate this area.

NC	Areas Reviewed (continued)	Findings
X	There was an EHR quality review committee, and the review process complied with selected requirements.	• The facility did not provide documented evidence of compliance in the timeframe needed to fully evaluate this area.
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
X	Use and review of blood/transfusions complied with selected requirements.	• The facility did not provide all documented evidence of compliance in the timeframe needed to fully evaluate this area. Four quarters of Blood Usage Committee meeting attendance rosters reviewed: • Surgery, Medicine, and Anesthesia Service representatives did not attend Blood Usage Committee meetings during the last 4 quarters.
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
X	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	The facility did not provide all documented evidence of compliance in the timeframe needed to fully evaluate this area. However, we did review 4 quarters of Medical Executive Committee and Quality Leadership Team meeting minutes: • Minutes did not reflect discussion of improvement opportunities or track actions to completion for IPEC data and the copy and paste function. This was a repeat finding from the previous CAP review.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
X	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	• The facility did not provide all documented evidence of compliance in the timeframe needed to fully evaluate the program. The documents that were provided did not support that the facility had a comprehensive and effective QM program.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the senior-level committee responsible for QM and performance improvement include the facility Director as a member.

2. We recommended that senior leaders routinely discuss the facility's IPEC data and ensure that discussions are documented in the minutes of a senior-level committee.

3. We recommended that the facility Director ensure that the peer review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

4. We recommended that the local observation bed policy be revised to include that each observation patient must have a focused goal for the period of observation and that each admission must have a clinical condition that is appropriate for observation.

5. We recommended that the facility Director ensure that the observation bed review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

6. We recommended that the facility Director ensure that the cardiopulmonary resuscitation review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

7. We recommended that the facility Director ensure that the EHR quality review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

8. We recommended that the facility Director ensure that the blood usage review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

9. We recommended that processes be strengthened to ensure that representatives from Surgery, Medicine, and Anesthesia Services attend Blood Usage Committee meetings.

10. We recommended that processes be strengthened to ensure that Medical Executive Committee and Quality Leadership Team minutes reflect discussion of improvement opportunities and track actions taken to completion for IPEC data and the copy and paste function.

11. We recommended that the facility conduct a full evaluation of QM processes to determine whether improvements are needed to ensure a comprehensive and effective program that monitors all required components.

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 and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected four CLC units, one intensive care unit, one medical/surgical unit, the outpatient clinic, and SPS. The facility did not have a hemodialysis program. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed six SPS employee training and competency files. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• The vents in all seven patient care areas were dusty and dirty.
	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 VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Hemodialysis	
NA	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	
NA	Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
NA	Employees received training on bloodborne pathogens.	
NA	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
NA	Selected EOC/infection prevention/safety requirements were met.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	
NA	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
	Employees received required RME training and competency assessment.	
NA	Operating room employees who performed immediate use (flash) sterilization received training and competency assessment.	
X	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	RME standard operating procedures and manufacturers' instructions for eight critical and semi-critical items reviewed: • Five of the standard operating procedures and manufacturers' instructions were not consistent. This was a repeat finding from the previous CAP review.
	Selected infection prevention/environmental safety requirements were met.	
	Selected requirements for SPS decontamination and sterile storage areas were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

12. We recommended that processes be strengthened to ensure that vents in patient care areas are clean and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that RME standard operating procedures and manufacturers' instructions are consistent.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • CS inspectors did not receive annual updates or refresher training.
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Documentation and monthly inspection reports of 10 CS areas inspected January–August 2013 reviewed: • Monthly inspections of all required non-pharmacy areas were missed during February and March. • For completed inspections in 4 of the 10 areas, not all required elements were addressed.

NC	Areas Reviewed (continued)	Findings
X	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	Documentation and monthly inspection reports of pharmacy CS inspections January–August 2013 reviewed: • Monthly inspections of all required pharmacy areas were missed during February and March. • For completed inspections, not all required elements were addressed.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

14. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates or refresher training.

15. We recommended that processes be strengthened to ensure that monthly inspections of all non-pharmacy areas with CS are conducted and include all required elements and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy areas are conducted and include all required elements and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
X	HPC staff and selected non-HPC staff had end-of-life training.	• There was no evidence that three non-HPC staff had end-of-life training.
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	

NC	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

17. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 6 EHRs of patients with pressure ulcers (5 patients with community-acquired pressure ulcers and 1 patient with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
X	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	• The facility did not have an interprofessional pressure ulcer committee.
X	Pressure ulcer data was analyzed and reported to facility executive leadership.	Minutes of Nursing Quality Leadership Committee for past 6 months reviewed: • Pressure ulcer data was not analyzed or reported to facility executive leadership.
X	Complete skin assessments were performed within 24 hours of acute care admissions.	• Three of the six EHRs did not contain documentation that staff conducted a complete skin assessment within 24 hours of admission.
X	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	• None of the four applicable EHRs contained documentation that a skin inspection and risk scale were performed at discharge.
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In two of the six EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• None of the six EHRs contained consistent documentation that staff performed daily risk scales and/or daily skin inspections.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
NA	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NC	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • None of the five applicable EHRs contained evidence that education was provided.
X	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	Facility pressure ulcer staff education requirements reviewed: • Seven employee training records did not contain evidence of training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, or how to accurately document findings.
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

18. We recommended that the facility establish an interprofessional pressure ulcer committee with appropriate membership, including a certified wound care specialist.

19. We recommended that the facility analyze pressure ulcer data and report it to facility executive leadership.

20. We recommended that processes be strengthened to ensure that acute care staff perform and document a complete skin assessment on all patients within 24 hours of admission and that compliance be monitored.

21. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

22. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

23. We recommended that processes be strengthened to ensure that acute care staff consistently perform and document daily risk scales and daily skin inspections for patients at risk for or with pressure ulcers and that compliance be monitored.

24. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

25. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to accurately document findings and that compliance be monitored.

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 two inpatient units (acute medical/surgical and long-term care).[6]

We reviewed relevant documents and 32 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 13B/15B and CLC unit 12A for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
X	Members of the expert panels completed the required training.	• None of the 12 members of the unit-based expert panels had completed the required training. • Eleven of the 21 members of the facility expert panel had not completed the required training.
	The 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 VHA or local policy.	

Recommendation

26. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Construction Safety

The purpose of this review was to determine whether the facility maintained IC and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected the 13A Renovation for Endoscopy Suite project. Additionally, we reviewed relevant documents and 16 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee IC and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
X	IC, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • The IC risk assessment was not reviewed prior to project initiation. • The tuberculosis risk assessment was not conducted prior to project initiation.
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
X	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	Site inspection documentation for 2 quarters reviewed: • We did not find documented evidence that all required multidisciplinary team members participated in site inspections. • We did not find documented evidence of the time of the inspections.
X	IC Committee minutes documented infection surveillance activities associated with the project and any interventions.	IC Committee minutes for past 2 quarters reviewed: • There was no documentation of infection surveillance activities related to the project.
X	CSC minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	CSC minutes for past 2 quarters reviewed: • There was no documentation of unsafe conditions in any of the daily inspections.

NC	Areas Reviewed (continued)	Findings
X	Contractors and designated VA employees received required training.	• The facility did not provide documented evidence that contractors received OSHA Construction Safety training. Employee training records reviewed: • Four employee records did not contain evidence of initial VHA or OSHA Construction Safety training. • Five employee records did not contain evidence of at least 10 hours of construction safety training in the past 2 years.
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

27. We recommended that processes be strengthened to ensure that IC and tuberculosis risk assessments are conducted and reviewed prior to construction project initiation.

28. We recommended that all required members of the multidisciplinary CSC participate in construction site inspections and that inspection documentation includes the time of the inspection and the names of those who participated.

29. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC minutes.

30. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of any unsafe conditions identified in daily inspections.

31. We recommended that processes be strengthened to ensure that contractors receive OSHA Construction Safety training prior to project initiation.

32. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

MH RRTP

The purpose of this review was to determine whether the facility's domiciliary, Domiciliary Care for Homeless Veterans Program, Substance Abuse Residential Rehabilitation Treatment Program, and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program, complied with selected EOC requirements.[8]

We reviewed relevant documents, inspected units 8B and 16B, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
NA	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
X	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements; work orders were submitted for items needing repair; and any identified deficiencies were corrected.	• The facility only began conducting self-inspections in May 2013.
X	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	• Daily bed checks and weekly contraband inspections were not consistently documented.
X	Written agreements acknowledging resident responsibility for medication security were in place.	• Written agreements were not in place on the units.
X	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• The units' main points of entry did not have keyless entry.
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
X	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the processes.	• The facility did not have written processes in place for responding to behavioral health and medical emergencies.
NA	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NC	Areas Reviewed (continued)	Findings
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

33. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted and documented.

34. We recommended that processes be strengthened to ensure that MH RRTP employees perform and document daily bed checks and weekly contraband inspections and that compliance be monitored.

35. We recommended that processes be strengthened to ensure that written agreements acknowledging resident responsibility for medication security are in place.

36. We recommended that the MH RRTP units' main points of entry have keyless entry systems.

37. We recommended that the facility implement written processes to address behavioral health and medical emergencies and that MH RRTP employees are aware of the actions to be taken.

Facility Profile (Dublin/557) FY 2013 through May 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-affiliated
Total Medical Care Budget in Millions	$204.1
Number (through June 2013) of:	
• **Unique Patients**	30,247
• **Outpatient Visits**	198,498
• **Unique Employees**[b]	1,163
Type and Number of Operating Beds:	
• **Hospital**	34
• **CLC**	161
• **Mental Health**	145
Average Daily Census:	
• **Hospital**	16
• **CLC**	139
• **Mental Health**	88
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Macon/557GA Albany/557GB Baldwin County/557GC Brunswick/557GE Perry/557HA
VISN Number	7

[a] All data is for FY 2013 through May 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012	FY 2013	FY 2012			
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	65.7	66.8	50.4	50.4	45.2	50.0
VISN	65.9	65.2	51.8	51.3	50.6	51.1
VHA	65.0	65.5	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] 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.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	16.0	12.0	12.8	**	22.5	20.9
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[c] 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. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] 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.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 5, 2013

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Carl Vinson VA Medical Center, Dublin, GA**

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

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

I concur with the recommendations and approve the action plans as outlined by the Carl Vinson VA Medical Center.

Charles E. Sepich, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 5, 2013

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **CAP Review of the Carl Vinson VA Medical Center, Dublin, GA**

To: Director, VA Southeast Network (10N7)

1. I concur with the recommendations in the Combined Assessment Program Review of the Carl Vinson VA Medical Center.

2. Thank you for this opportunity to review the draft report. Attached are the facility actions taken as a result of these findings.

3. If you have additional questions or need further information, please contact me at (478) 272-1210, ext. 2901.

John S. Goldman
Director, Carl Vinson VA Medical Center (557/00)

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 senior-level committee responsible for QM and performance improvement include the facility Director as a member.

Concur

Target date for completion: Completed

Facility response: The senior level committee for CVVAMC is the Executive Leadership Team (ELT) which was established by Medical Center Memorandum No. 00-09, dated August 8, 2013. The chairperson for this committee is the Medical Center Director. Members of this committee also include the Patient Safety Manager as well as the Chief of Quality Management. The ELT meets quarterly and has oversight over all QM and performance improvement initiatives.

Recommendation 2. We recommended that senior leaders routinely discuss the facility's IPEC data and ensure that discussions are documented in the minutes of a senior-level committee.

Concur

Target date for completion: December 31, 2013

Facility response: CVVAMC leadership discussed IPEC data during the November 2013 CPR and Infection Control Committees. IPEC data was discussed and documented in the Medical Executive Committee (MEC) during the November meeting and will be discussed at least quarterly in ELT, beginning with the December 2013 meeting.

Recommendation 3. We recommended that the facility Director ensure that the peer review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

Concur

Target date for completion: December 17, 2013

Facility response: The Risk Manager has developed a checklist used to ensure that all elements of the peer review process are completed in accordance with VA Policy. This checklist is completed for every peer review and monitored by the Risk Manager on an ongoing basis. Also, the Peer Review Committee (PRC) minute's format has been revised to ensure compliance with established guidelines reflecting all the required

elements. The new format will be used at the next Peer Review Committee scheduled for December 5, 2013. The PRC will report to the MEC quarterly for discussion of findings, trends, and actions taken. To ensure evidence of compliance is readily available, the Risk Manager will maintain all files in a secure, centralized location.

Recommendation 4. We recommended that the local observation bed policy be revised to include that each observation patient must have a focused goal for the period of observation and that each admission must have a clinical condition that is appropriate for observation.

Concur

Target date for completion: Completed

Facility response: Observation Bed Policy was revised and published on November 22, 2013. The new policy includes requirements that each observation patient must have a focused goal for the period of observation and that each admission must have a clinical condition that is appropriate for observation.

Recommendation 5. We recommended that the facility Director ensure that the observation bed review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

Concur

Target date for completion: December 9, 2013

Facility response: Medical Center Memorandum (MCM) 11-113 (Observation Care Beds) was revised to include added responsibilities for UM to include daily contact with providers and reviewing cases in daily clinical meetings. A representative from UM will submit tracking, trending and analysis of the data on a quarterly basis to the Quality Leadership Team (QLT). The report will include number and conversion rate of observations to admissions and percentage of compliance with admission criteria.

Recommendation 6. We recommended that the facility Director ensure that the cardiopulmonary resuscitation review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

Concur

Target date for completion: January 31, 2014

Facility response: During the October 2013 quarterly meeting, the CPR committee revised the committee minute template to include additional information required per VHA Directive 2008-063. Each CPR event was reviewed in detail with trends and opportunities for improvement identified. Actions taken will be tracked through closure in the CPR Committee minutes. Data was reported in Medical Executive Committee

(MEC) during the November 2013 meeting. To ensure documented evidence of compliance is readily available, the CPR Committee Chairperson will maintain all documentation. The next quarterly CPR Committee is scheduled for January 2014.

Recommendation 7. We recommended that the facility Director ensure that the EHR quality review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

Concur

Target date for completion: Completed

Facility response: The MRC conducted a comprehensive review of the structure and the committee's meeting minutes to ensure compliance with VHA Handbook 1909.01. The committee's minute's format was revised to ensure full compliance and to ensure that the minutes document EHR quality reviews from all services and quarterly monitoring reports for the copy and paste function. The use of the new format started with the meeting on October 29, 2013. Quality Management will review committee minutes for 90 days to validate compliance and maintain copies of all minutes to ensure that data and analysis are readily available.

Recommendation 8. We recommended that the facility Director ensure that the blood usage review process meets applicable requirements and is monitored on an ongoing basis and that documented evidence of compliance be readily available.

Concur

Target date for completion: December 16, 2013

Facility response: CVVAMC will ensure that blood usage and review process meets applicable requirements to include the results of proficiency testing, peer reviews, and external reviews. These elements will be standing agenda items for the Blood Usage Review Committee Meeting. The Blood Usage Review Committee will meet on December 5, 2013 and reports quarterly to the MEC. Quality Management will review minutes to validate compliance and maintain copies of all minutes to ensure that data and analysis are readily available.

Recommendation 9. We recommended that processes be strengthened to ensure that representatives from Surgery, Medicine, and Anesthesia Services attend Blood Usage Committee meetings.

Concur

Target date for completion: December 17, 2013

Facility response: The Blood Usage Committee Chairperson communicated to all members of the committee of the requirement to attend each meeting. This was electronically communicated as well by signed memoranda. The quorum for the

November 2013 meeting was achieved and members present included representatives from surgery, medicine, and anesthesia service lines.

Recommendation 10. We recommended that processes be strengthened to ensure that Medical Executive Committee and Quality Leadership Team minutes reflect discussion of improvement opportunities and track actions taken to completion for IPEC data and the copy and paste function.

Concur

Target date for completion: December 17, 2013

Facility response: IPEC data will be discussed at the CPR and Infection Control Committees. The minutes will include an analysis of the aggregated IPEC data to include opportunities for improvement and actions taken. The results will be reported quarterly to the Medical Executive Committee (MEC). The copy and paste function will be a quarterly monitor for the Medical Records Committee.

Recommendation 11. We recommended that the facility conduct a full evaluation of QM processes to determine whether improvements are needed to ensure a comprehensive and effective program that monitors all required components.

Concur

Target date for completion: December 13, 2013.

Facility response: A comprehensive external review of the facility's Quality Management program is currently in process.

Recommendation 12. We recommended that processes be strengthened to ensure that vents in patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: During the survey process, the Engineering Services Leadership conducted a full inspection of all vents and ensured that they were properly cleaned. Cleaning of vents in patient care areas was completed on September 20, 2013.

To ensure this cleanliness is maintained, a preventive maintenance schedule has been developed within VISTA.

Recommendation 13. We recommended that processes be strengthened to ensure that RME standard operating procedures and manufacturers' instructions are consistent.

Concur

Target date for completion: Completed

Facility response: SOPs identified in the review were updated to reflect the manufacturers' recommendation on October 23, 2013. SPS staff initiated a review and compared all facility RME SOPs with manufacturer's instructions. The full review was completed on November 27, 2013. The RME committee will be updated monthly on new and/or updated SOPs and staff competency related to the new and /or updated SOPs to ensure sustainability/compliance.

Recommendation 14. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates or refresher training.

Concur

Target date for completion: Completed

Facility response: All Controlled Substance Inspectors (CSI) have completed the TMS training. The Controlled Substance Coordinator (CSC) has a printed copy of each CSI's certificate on file. To maintain competency, all CSI will be assigned annual TMS training for completion. In addition, the CSC will conduct an annual refresher training which will include any pertinent updates. Documentation of training will be kept by the CSC.

Recommendation 15. We recommended that processes be strengthened to ensure that monthly inspections of all non-pharmacy areas with CS are conducted and include all required elements and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: Monthly inspections are scheduled to provide a strict timeframe for inspection completion. Education has also been provided to inspectors concerning assigned inspection guidelines, timeframes, and inspector responsibilities if unable to perform a scheduled inspection. The current SOP outlines these requirements, timeframes and guidelines. The Control Substance Coordinator sends a monthly report to the Medical Center Director which will include inspection reports of all required non-pharmacy areas with CS as well as compliance to required elements. A quarterly trend report is also submitted to the Medical Center Director which will identify trends regarding compliance or non-compliance with selected elements. To strengthen the process and assist with compliance monitoring, the Executive Assistant (EA) to the

Director will also receive and review the monthly and quarterly reports prior to submission to the Medical Center Director.

Recommendation 16. We recommended that processes be strengthened to ensure that monthly inspections of all pharmacy areas are conducted and include all required elements and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: Compliance with the VHA Handbook 1108.2, "Inspection of Controlled Substances," was validated in October 2013 by the Controlled Substance Coordinator. A review of seven consecutive months of inspections resulted in 100% compliance. Monthly inspections do include inpatient pharmacy, the outpatient pharmacy, the CLC vault and the emergency drug cache. The Control Substance Coordinator sends a monthly report to the Medical Center Director which will include inspection reports of all required pharmacy areas with CS as well as compliance to required elements. A quarterly trend report is also submitted to the Medical Center Director which will identify trends regarding compliance or non-compliance with selected elements. To strengthen the process and assist with compliance monitoring, the Executive Assistant (EA) to the Director will also receive and review the monthly and quarterly reports prior to submission to the Medical Center Director.

Recommendation 17. We recommended that processes be strengthened to ensure that all non-HPC clinical staff who provide care to patients at the end of their lives receive end-of-life training.

Concur

Target date for completion: December 31, 2013

Facility response: All non-HPC clinical staff that provide care to patients at the end of their lives are scheduled to attend "End of Life Training." This training will be provided throughout the day to capture the various shifts. Follow up training will be scheduled on an as needed basis for those not able to attend the scheduled training. Training is scheduled for December 4, 2013 in the medical center auditorium. This training will be conducted for all appropriate new employees and annually thereafter. Monitoring will be conducted by the Chief of Social Work who will submit compliance reports to the QLT every 6 months. The training requirement will be added to each person's TMS curriculum.

Recommendation 18. We recommended that the facility establish an interprofessional pressure ulcer committee with appropriate membership, including a certified wound care specialist.

Concur

Target date for completion: Completed

Facility response: The CVVAMC chartered an interprofessional Pressure Ulcer Committee on November 22, 2013. A formal policy is currently in development which will outline the specific functions, expected outcomes, metrics, and reporting structure to ensure compliance to VHA handbook 1180-02, *Prevention of Pressure Ulcers*. The first meeting of the Pressure Ulcer Committee was held November 26, 2013.

Recommendation 19. We recommended that the facility analyze pressure ulcer data and report it to facility executive leadership.

Concur

Target date for completion: December 31, 2013

Facility response: Data will be tracked, trended, and reported by the Wound Care Nurse to the Pressure Ulcer Committee on a monthly basis. The data will be presented to the ELT no less than four times a year beginning with the December 2013 meeting.

Recommendation 20. We recommended that processes be strengthened to ensure that acute care staff perform and document a complete skin assessment on all patients within 24 hours of admission and that compliance be monitored.

Concur

Target date for completion: December 31, 2013

Facility response: All patients admitted to acute care unit will have a skin assessment completed within 24 hours of admission per VHA Handbook 1180-02. Audits for all acute care units for the month of September and October were conducted. Results demonstrated 100% compliance with guidelines. Data will be tracked, trended, and reported by the Wound Care Nurse to the Pressure Ulcer Committee at least quarterly starting with the December 2013 meeting.

Recommendation 21. We recommended that processes be strengthened to ensure that acute care staff perform and document a patient skin inspection and risk scale at discharge and that compliance be monitored.

Concur

Target date for completion: January 28, 2014

Facility response: The wound care nurse audits 100% of all patients who are discharged with pressure ulcers to ensure that patient skin inspections and risk scales are documented at discharge. The data will be reported monthly to the Pressure Ulcer Committee.

Recommendation 22. We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 28, 2014

Facility response: Acute care staff will accurately document location, stage and/or risk scale score for all pressure ulcer patients and documented evidence of compliance will be available. To confirm compliance, the Nurse Quality Coordination will conduct random audits utilizing the ADC of patients meeting criteria. The data will be reported monthly to the Pressure Ulcer Committee.

Recommendation 23. We recommended that processes be strengthened to ensure that acute care staff consistently perform and document daily risk scales and daily skin inspections for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 28, 2014

Facility response: Further training is being provided for the nursing staff on acute care units regarding the assessment and documentation of pressure ulcers. Completed training will be tracked for 100% nursing staff completion. Post-training monitoring of pressure ulcer documentation and accuracy will be conducted as part the established pressure ulcer review. Results will be reported at the Pressure Ulcer Committee and Nurse Executive Council.

Recommendation 24. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: January 28, 2014

Facility response: To ensure that staff are documenting the education provided to patients at risk for pressure ulcers and their caregivers, the Wound Care Nurse will reinforce the training on the method of documenting this in the electronic health record. The Nurse Quality Coordinator or designee will be responsible for auditing, tracking and

trending results for compliance with established guidelines. Results will be reported to the Pressure Ulcer Committee.

Recommendation 25. We recommended that processes be strengthened to ensure that designated employees receive training on how to administer the pressure ulcer risk scale, how to conduct a complete skin assessment, and how to accurately document findings and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: Training to administer the pressure ulcer risk scale, how to conduct a complete skin assessment and how to accurately document the findings have been completed by 100% of the acute care nursing staff. The competency model was completed via the learning plans in the Talent Management System (TMS). Compliance will be tracked through delinquency reports that are automatically generated by TMS and sent to supervisors. Compliance to documentation requirements will be recurring reports for the Pressure Ulcer Committee.

Recommendation 26. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: Completed

Facility response: As of November 2013, 43 of the 43 members of the Unit Based Expert Panel have completed training and 21 of the 21 members of the Facility Expert Panel have completed the training. The training has been completed and documented prior to the completion of the next annual staffing plan assessment.

Recommendation 27. We recommended that processes be strengthened to ensure that IC and tuberculosis risk assessments are conducted and reviewed prior to construction project initiation.

Concur

Target date for completion: Completed

Facility response: The current ISL audit tool reflects that TB risk is addressed prior to all new construction projects. To strengthen the program, a revised Safety & Health During Construction Activities policy (MCM 138-452) has been approved and published stipulating that all contracted construction employees assigned to the work site will have a pre-placement negative TB screening completed 90 days prior to working on any project. The process will continue to be reported during the Construction Safety Committee.

Recommendation 28. We recommended that all required members of the multidisciplinary CSC participate in construction site inspections and that inspection documentation includes the time of the inspection and the names of those who participated.

Concur

Target date for completion: Completed

Facility response: The Chief of Engineering Services has communicated to all members of the CSC of the requirement for them to participate in construction site inspections. CVVAMC's policy MCM 138-452, "Safety & Health During Construction Activities" has been revised to include construction site inspection form (including dates, times and names of participants as well as inspection findings) and when it will be completed.

Recommendation 29. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC minutes.

Concur

Target date for completion: Completed

Facility response: All infection surveillance activities related to construction projects are now captured in the monthly Infection Control Committee (ICC) minutes. September 25, 2013, the first ICC meeting, post-survey, deficiencies as they relate to construction projects were reported and recorded in the minutes. All issues including identified solutions will be tracked to completion and will be documented in the ICC Minutes.

Recommendation 30. We recommended that processes be strengthened to ensure that CSC minutes contain documentation of any unsafe conditions identified in daily inspections.

Concur

Target date for completion: Completed

Facility response: CVVAMC's policy MCM 138-244 (Access/Exposure Control Program) Appendix C (Daily Construction inspection Report) has been revised to include a field for "Unsafe Conditions." MCM 138-452, "Safety & Health During Construction Activities" was revised to mandate review of unsafe conditions at each Construction Safety Committee meeting. All stakeholders have been educated of the latest updates.

Recommendation 31. We recommended that processes be strengthened to ensure that contractors receive OSHA Construction Safety training prior to project initiation.

Concur

Target date for completion: Completed

Facility response: CVVAMC updated MCM 138-452, "Safety & Health During Construction Activities" to reflect that all contractors submit proof of successful completion of required OSHA training before requests for temporary identification badges are issued. The data will be monitored by the Pre-Construction Committee.

Recommendation 32. We recommended that processes be strengthened to ensure that designated employees receive initial and ongoing construction safety training and that compliance be monitored.

Concur

Target date for completion: Completed.

Facility response: Training for all members of the Construction Safety Committee has been completed. Individual training plans for Construction Safety Committee members have been updated to include 2 year construction safety refresher training. This training will be monitored and tracked using Talent Management System (TMS), where the curriculum has been added to all applicable employee profiles. TMS provides timely alerts to employees and supervisors.

Recommendation 33. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections are conducted and documented.

Concur

Target date for completion: Completed

Facility response: The self-assessment tool used for monthly inspections in the Domiciliary includes all required elements as described in VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*. Monthly self-inspections were initiated in May 2013 and have been completed each month since. Compliance with this requirement will continue to be tracked by the Domiciliary Chief.

Recommendation 34. We recommended that processes be strengthened to ensure that MH RRTP employees perform and document daily bed checks and weekly contraband inspections and that compliance be monitored.

Concur

Target date for completion: Completed

Facility response: The daily bed checks and weekly contraband audit tool have been amended to reflect all VHA requirements. The revised audit tool is currently in use. The Domiciliary Chief will monitor compliance through self-inspections. The Associate Chief of Mental Health and the Mental Health Business Manager or their designee will conduct a 100% review of reports for 90 days to ensure compliance.

Recommendation 35. We recommended that processes be strengthened to ensure that written agreements acknowledging resident responsibility for medication security are in place.

Concur

Target date for completion: Completed

Facility response: A facility policy is in place to govern requirements for the medication management program (MCM 00-345). All participants in the MH RRTP are provided and educated on Attachment #1 (Hand Carried Medication Guidelines) and Attachment #2 (Acknowledgement of Agreement signature page). To ensure the continued integrity of the program, all completed and signed Acknowledgement of Agreement forms are forwarded to Health Administration Service (HAS) to be scanned into the resident's EHR. Audits will be conducted by the Domiciliary Chief for all new admissions each month for 3 months to ensure documents are in the EHR.

Recommendation 36. We recommended that the MH RRTP units' main points of entry have keyless entry systems.

Concur

Target date for completion: Completed

Facility response: All occupied units that require keyless entry have keyless entry systems installed.

Recommendation 37. We recommended that the facility implement written processes to address behavioral health and medical emergencies and that MH RRTP employees are aware of the actions to be taken.

Concur

Target date for completion: Completed

Facility response: Written processes to address behavioral and medical emergencies in the RRTP are addressed in medical center policies MCM 11-370 (Rapid Response Team) and Plan 00-273 (Cardiopulmonary Resuscitation Plan) which specifically speak to medical emergencies and in MCM 00-141 (Veterans Presenting with Mental Health Emergencies). MH RRTP staff will continue to complete required training (CPR, competencies, and annual training) which is tracked using Talent Management System (TMS).

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
- 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*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.

[2] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
- VHA Directive 2009-026, *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, May 13, 2009.
- VA National Center for Patient Safety, "Look-Alike Hemodialysis Solutions," Patient Safety Alert 11-09, September 12, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- Various requirements of The Joint Commission, the Centers for Disease Control and Prevention, OSHA, the National Fire Protection Association, the American National Standards Institute, the Association for the Advancement of Medical Instrumentation, the International Association of Healthcare Central Service Materiel Management, and the Association for Professionals in IC and Epidemiology.

[3] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA, "Clarification of Procedures for Reporting Controlled Substance Medication Loss as Found in VHA Handbook 1108.01," Information Letter 10-2011-004, April 12, 2011.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/2, *Security and Law Enforcement*, May 27, 2010.

[4] References used for this topic included:
- VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008.
- VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
- VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, July 2, 2009.
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Directive 2009-053, *Pain Management*, October 28, 2009.
- Under Secretary for Health, "Hospice and Palliative Care are Part of the VA Benefits Package for Enrolled Veterans in State Veterans Homes," Information Letter 10-2012-001, January 13, 2012.

[5] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[6] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[7] References used for this topic included:
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 2011.
- VA Office of Construction and Facilities Management, *Master Construction Specifications*, Div. 1, "Special Sections," Div. 01 00 00, "General Requirements," Sec. 1.5, "Fire Safety."
- Various Centers for Disease Control and Prevention recommendations and guidelines, Joint Commission standards, and OSHA regulations.

[8] References used for this topic included:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and National Fire Protection Association.