Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03653-91

Combined Assessment Program Review of the Atlanta VA Medical Center Decatur, Georgia

March 12, 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
ED	emergency department
EHR	electronic health record
EOC	environment of care
EQUiPPED	Enhancing Quality of Prescribing Practices for Elderly Veterans Discharged from the Emergency Department
facility	Atlanta VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MSIT	Multidisciplinary Safety Inspection Team
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
ROM	range of motion
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 November 18, 2013.

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

- Medication Management
- Coordination of Care

The facility's reported accomplishments were medication management for elderly veterans and improved access to dermatology care.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that actions from peer reviews are completed and reported to the Peer Review Committee and that quarterly summary reports are sent to the Medical Executive Committee. Require the Cardiopulmonary Resuscitation Committee to review each code episode and collect code data. Ensure the Surgical Work Group meets monthly and documents its review of required performance data elements and National Surgical Office reports. Require the quality control policy for scanning to include how to annotate a scanned image to identify that it has been scanned. Ensure that the Anesthesia Service representative attends Blood Usage Committee meetings and that the blood/transfusion usage review process includes the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

Environment of Care: Secure medication carts at all times. Ensure all staff on the locked mental health unit and Multidisciplinary Safety Inspection Team members receive the required training. Require that locked mental health unit panic alarm testing documentation includes VA Police response times. Ensure that the locked mental health unit's seclusion room door opens towards the hallway and that patients in seclusion have privacy while using the bathroom.

Nurse Staffing: Ensure that annual staffing plan reassessments are completed timely and that members of the identified unit-based expert panel receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management: Ensure that the newly established interprofessional pressure ulcer committee continues to meet and that the committee provides oversight of the pressure ulcer prevention program. Accurately document pressure ulcer location, stage, risk scale score, and date acquired for all patients with

pressure ulcers. Perform and document daily risk scales for patients at risk for or with pressure ulcers, and document daily skin inspections for all hospitalized patients identified as not being at risk for pressure ulcers. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies. Provide and document pressure ulcer education to patients at risk for and with pressure ulcers and/or their caregivers.

Community Living Center Resident Independence and Dignity: Ensure all employees who perform restorative nursing services receive training on and competency assessment for range of motion and resident transfers.

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 20–27, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

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 seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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, FY 2013, and FY 2014 through November 22, 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 Atlanta VA Medical Center, Decatur, Georgia,* Report No. 08-03089-116, April 27, 2009). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 158 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 291 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.

Reported Accomplishments

Medication Management for Elderly Veterans

The facility is one of five VA medical centers participating in the quality improvement initiative EQUiPPED. The aim of the initiative is to avoid the use of potentially inappropriate medications in veterans age 65 or older at the time of ED discharge. ED providers receive electronic decision support via geriatric pharmacy order sets and links to online clinical resources, tools, and education. ED providers also receive individual feedback and peer benchmarking. Baseline EQUiPPED data for the facility in May 2012 showed that 14.7 percent of all medications prescribed to targeted veterans were potentially inappropriate. In September 2013 (post-EQUiPPED interventions), the percentage of prescribed potentially inappropriate medications decreased to 5.45 percent. The use of appropriate medications by staff providers was nearly three times more likely after the initiative.

Access to Dermatology Care

The facility's efforts to improve access to dermatology care began in 2012 with 2 related efforts (1) receipt of national funding to develop a dermatology mini-residency program and (2) initiation of teledermatology. The goal was to educate primary care providers to manage simple dermatological problems and to educate treatment team members on the use of teledermatology technology. For the period February 1 to March 31, 2013, the facility recognized a 39 percent decrease in face-to-face new consults to Dermatology Service and a 10 percent decrease in face-to-face follow-up visits when compared to the same timeframe in 2012. Access has improved, and the next available new patient appointment is now within 2 weeks. Currently, the teledermatology program sees approximately 200 consults per month, with an average turnaround time of less than 24 hours for image reading.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • None of the 20 actions expected to be completed were reported to the PRC. This was a repeat finding from the previous CAP review. Twelve months of MEC meeting minutes reviewed: • None of the quarterly summary reports were documented as received by the MEC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Ten months of Cardiopulmonary Resuscitation Review Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each episode. • There was no evidence that data were collected.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group was not chartered until August 2013. As a result, there was no evidence that required monthly and quarterly performance data elements, such as local performance data and National Surgical Office reports, were reviewed.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include how to annotate a scanned image to identify that it has been scanned.

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Eight months of Blood Usage Review Committee meeting minutes reviewed: • A clinical representative for Anesthesia Service was not appointed until October 2013. • The review process did not include the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, or the results of inspections by government or private (peer) entities.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are completed and reported to the PRC.

2. We recommended that the PRC submit quarterly summary reports to the MEC and that the MEC document its discussion of the reports.

3. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode and collects code data.

4. We recommended that the Surgical Work Group meet monthly and document its review of required performance data elements and National Surgical Office reports.

5. We recommended that the quality control policy for scanning include how to annotate a scanned image to identify that it has been scanned.

6. We recommended that processes be strengthened to ensure that the Anesthesia Service representative attends Blood Usage Committee meetings and that the blood/transfusion usage review process includes the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

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 radiology and acute MH were met.[2]

We inspected 10 areas (medicine, surgery, the medical intensive care unit, the ED, CLC-2, the primary care clinic, the sleep clinic, x-ray, fluoroscopy, and acute MH). Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 29 employee training records (10 radiology employees, 10 acute MH unit employees, 4 MSIT members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed 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.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• Although the medication carts appeared to be locked in the five locations inspected that had carts, not all medication drawers were secured due to faulty locking mechanisms.
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter within the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
X	MH unit staff, MSIT members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	• Two of the locked MH unit staff, four MSIT members, and all five occasional locked MH unit staff had not completed training on how to identify and correct environmental hazards, the proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.
X	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• Although panic alarm testing was conducted, VA Police response times were not documented for the past 6 months. • The seclusion room door did not open toward the hallway.

NM	Areas Reviewed for Acute MH (continued)	Findings
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	VHA policy reviewed: • Patients in seclusion did not have privacy when using the bathroom.

Recommendations

7. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that all locked MH unit staff, MSIT members, and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, the proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing documentation includes VA Police response times.

10. We recommended that the locked MH unit's seclusion room door open towards the hallway and that patients in seclusion have privacy while using the bathroom.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and five training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 10, CLC-2, and MH unit 4—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• More than 15 months passed between initial implementation and the annual reassessment.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• None of the five members of CLC-2's unit-based expert panel had 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.	

Recommendations

11. We recommended that processes be strengthened to ensure that nursing managers complete annual staffing plan reassessments timely.

12. We recommended that all members of CLC-2's unit-based expert panel receive the required training prior to the next annual staffing plan reassessment.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 21 EHRs of patients with pressure ulcers (6 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 5 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	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.	• The interprofessional pressure ulcer committee was not established until October 2013.
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 13 of the 21 EHRs, documentation of location, stage, risk scale score, and/or date acquired varied.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Eight of the applicable 17 EHRs did not contain consistent documentation that staff performed daily risk scales.
	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.	
X	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.	• Two of the applicable seven EHRs did not contain evidence of wound care follow-up plans at discharge or evidence of patient receipt of dressing supplies prior to discharge.

NM	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.	Pressure ulcer patient and caregiver education requirements reviewed: • For 8 of the applicable 14 patients at risk for/with a pressure ulcer, EHRs did not contain evidence that education was provided.
	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.	
	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

13. We recommended that the newly established interprofessional pressure ulcer committee continue to meet and that the committee provide oversight of the facility's pressure ulcer prevention program.

14. 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.

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

16. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections for all hospitalized patients identified as not being at risk for pressure ulcers and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

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

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 11 EHRs of residents (10 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive ROM, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
X	Training and competency assessments were completed for staff who performed restorative nursing services.	• Eight employee training records did not contain evidence of ROM training, and none contained evidence of transfer training. • Two employee competency records did not contain evidence of ROM competencies, and none contained evidence of transfer competencies.
	The facility complied with any additional elements required by VHA or local policy.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

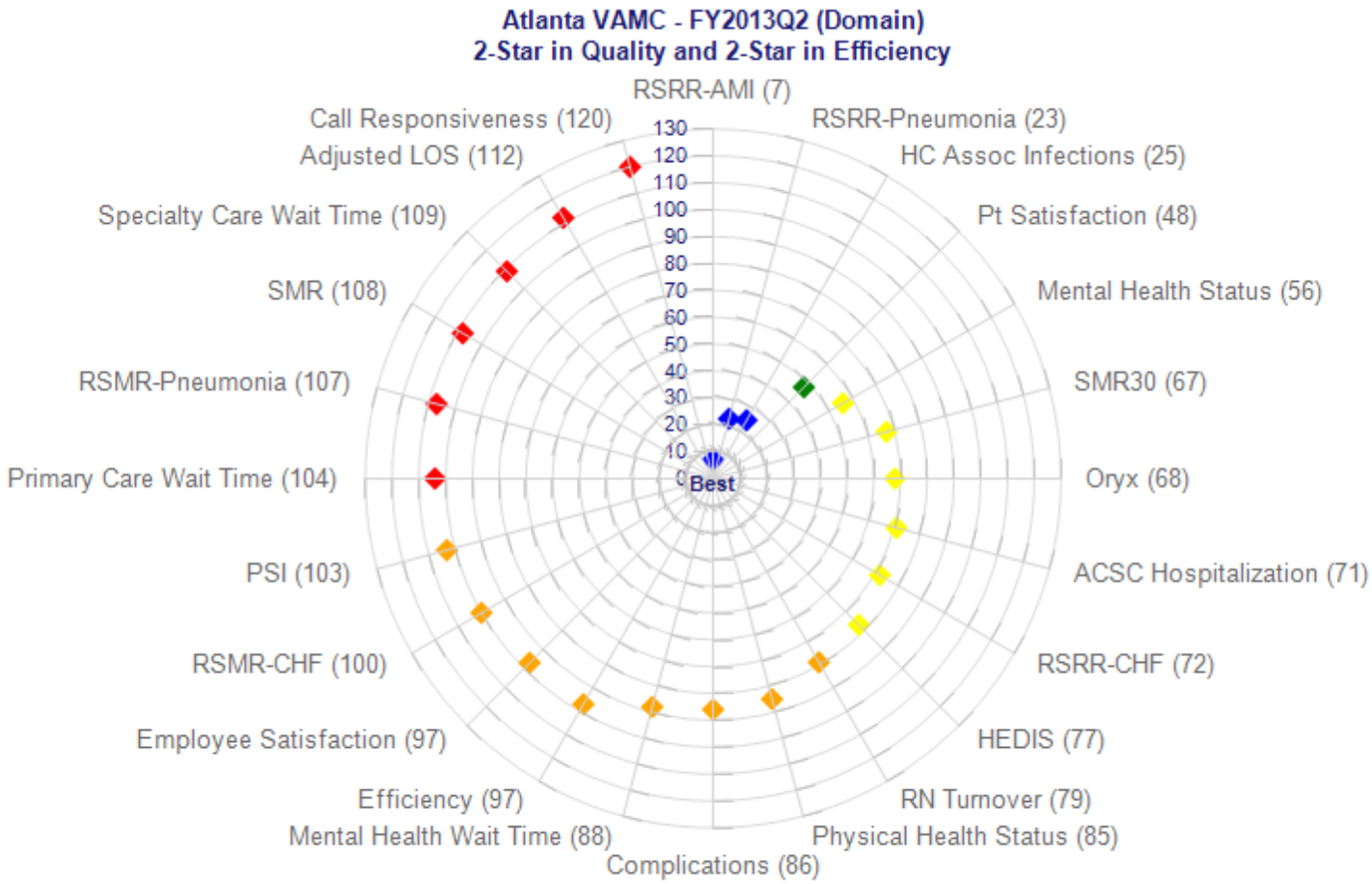
Recommendations

19. We recommended that processes be strengthened to ensure that all employees who perform restorative nursing services receive training on and competency assessment for ROM and resident transfers.

Facility Profile (Atlanta/508) FY 2014 through January 2014[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$600.3
Number of:	
• **Unique Patients**	66,524
• **Outpatient Visits**	323,345
• **Unique Employees**[b]	3,087
Type and Number of Operating Beds (December 2013):	
• **Hospital**	182
• **CLC**	77
• **MH**	40
Average Daily Census (November 2013):	
• **Hospital**	133
• **CLC**	62
• **MH**	28.8
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	East Point/508GA NE Georgia-Oakwood/508GE Austell/508GF Stockbridge/508GG Lawrenceville/508GH Newman/508GI Blairsville/508GJ Carrollton/508GK
VISN Number	7

[a] All data is for FY 2014 through January 2014 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

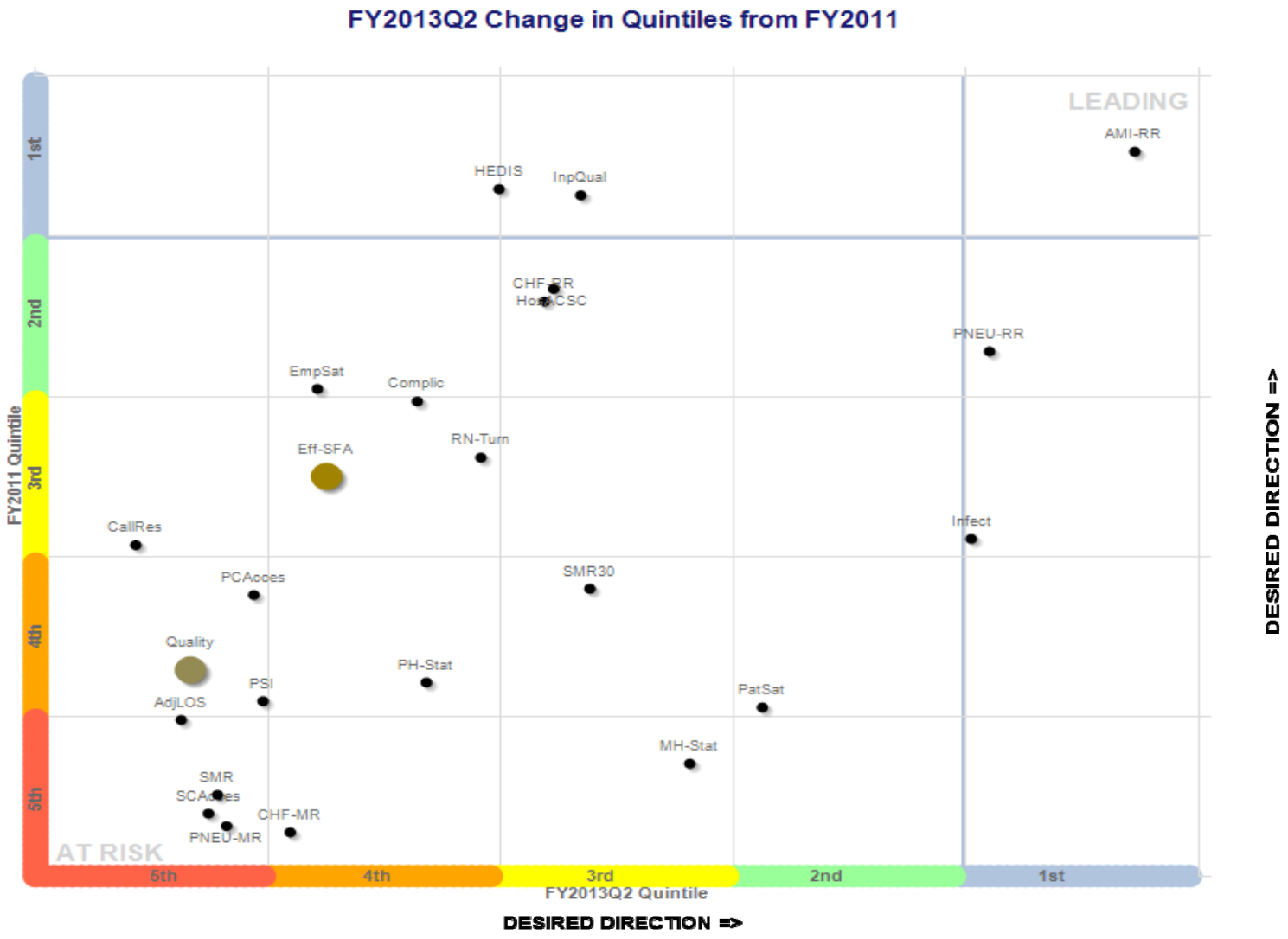
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 21, 2014

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Atlanta VA Medical Center, Decatur, GA**

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

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

1. I concur with the Atlanta VA Medical Center's responses and action plans as detailed within this report. VISN 7 will provide oversight and guidance, assuring that all improvements are completed and sustained.

2. If you have any questions related to this response, please contact Dr. Robin Hindsman, QMO, at 678-924-5723.

Charles E. Sepich, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 21, 2014

From: Director, Atlanta VA Medical Center (508/00)

Subject: **CAP Review of the Atlanta VA Medical Center, Decatur, GA**

To: Director, VA Southeast Network (10N7)

1. I concur with all of the findings and recommendations of the Office of Inspector General Combined Assessment Program Review of the Atlanta VA Medical Center, Decatur, GA.

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

Leslie Wiggins
Director, Atlanta VA Medical Center (508/00)

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 processes be strengthened to ensure that actions from peer reviews are completed and reported to the PRC.

Concur

Target date for completion: **Completed: December 10, 2013**

Facility response: A PRC issue tracking worksheet was implemented and has been included with the PRC minutes to track actions from peer reviews.

Recommendation 2. We recommended that the PRC submit quarterly summary reports to the MEC and that the MEC document its discussion of the reports.

Concur

Target date for completion: **Completed: December 10, 2013**

Facility response: The PRC quarterly summary has been added to the MEC reporting agenda to ensure descriptive documentation of minute discussion.

Recommendation 3. We recommended that processes be strengthened to ensure that the Cardiopulmonary Resuscitation Committee reviews each code episode and collects code data.

Concur

Target date for completion: **February 28, 2014**

Facility response: All CPR events are reviewed by Quality Management and identified issues are reviewed by the CPR Committee. The process has been strengthened to include reporting of aggregate data for all required elements reviewed for each resuscitation event.

Recommendation 4. We recommended that the Surgical Work Group meet monthly and document its review of required performance data elements and National Surgical Office reports.

Concur

Target date for completion: **Completed: January 21, 2014**

Facility response: The longstanding OR Committee which met monthly transitioned to a Surgical Work Group in August 2013. Review of required performance data elements and National Surgical reports has been documented in minutes since transition to a work group.

Recommendation 5. We recommended that the quality control policy for scanning include how to annotate a scanned image to identify that it has been scanned.

Concur

Target date for completion: **Completed: December 18, 2013**

Facility response: The Medical Records policy for scanning has been revised to include how to annotate a scanned image to identify that scanning has been completed.

Recommendation 6. We recommended that processes be strengthened to ensure that the Anesthesia Service representative attends Blood Usage Committee meetings and that the blood/transfusion usage review process includes the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

Concur

Target date for completion: **Completed: January 31, 2014**

Facility response: A new committee member from anesthesiology has been added and MCM 113-2 Blood Usage Review Committee has been revised to reflect membership composition. As of September 2013, the Blood Usage Committee meets applicable requirements to include documented review of proficiency testing results, peer reviews, and external reviews.

Recommendation 7. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

Concur

Target date for completion: **December 31, 2014**

Facility response: Nursing staff ensure medication carts are secured at all times. There are medication carts that do not have functional locking mechanisms and those carts are being repaired and/or replaced. Six carts have been received and an additional 26 carts are on order through a small business. The acquisition process is underway for the purchase of the remaining required carts. In the interim, medication carts are secured in a locked medication room unless in use. The BCMA Coordinator conducts routine rounding in all inpatient areas to ensure and document compliance.

Recommendation 8. We recommended that processes be strengthened to ensure that all locked MH unit staff, MSIT members, and occasional locked MH unit workers receive training on how to identify and correct environmental hazards, the proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units and that compliance be monitored.

Concur

Target date for completion: **March 31, 2014**

Facility response: Appropriate staff will complete the required training by March 31, 2014. The training modules will be added to identified employee's annual training requirement which will generate an electronic notice to the employee and employee's supervisor prior to due date of this annual requirement.

Recommendation 9. We recommended that processes be strengthened to ensure that locked MH unit panic alarm testing documentation includes VA Police response times.

Concur

Target date for completion: **Completed: January 27, 2014**

Facility response: Alarm testing documentation has been revised to include VA Police response times.

Recommendation 10. We recommended that the locked MH unit's seclusion room door open towards the hallway and that patients in seclusion have privacy while using the bathroom.

Concur

Target date for completion: **April 30, 2014**

Facility response: The existing inward swinging door in the seclusion room bathroom will be replaced with a new door and frame without a view panel. The new door has been ordered and will swing inward to maintain life safety egress clearances in the corridor and be equipped with features that also allow it to swing out into the corridor for emergency access.

Recommendation 11. We recommended that processes be strengthened to ensure that nursing managers complete annual staffing plan reassessments timely.

Concur

Target date for completion: **August 31, 2014**

Facility response: To ensure timely completion of the annual staffing reassessment, Unit Expert Panels will convene in June 2014. Recommendations are due to the Facility Expert Panel by July 31, 2014. All inpatient units have been completed.

Recommendation 12. We recommended that all members of CLC-2's unit-based expert panel receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: **May 31, 2014**

Facility response: All unit-based expert panels will receive the required training by May 31, 2014.

Recommendation 13. We recommended that the newly established interprofessional pressure ulcer committee continue to meet and that the committee provide oversight of the facility's pressure ulcer prevention program.

Concur

Target date for completion: **Completed: January 30, 2014**

Facility response: The facility's interprofessional Pressure Ulcer Committee provides oversight to the facility's pressure ulcer prevention program. The Pressure Ulcer Committee aggregates and analyzes data from a standardized pressure ulcer monitoring tool completed by Pressure Ulcer Champions. Discrepancy reports are sent to unit managers designating areas of improvement opportunity.

Recommendation 14. 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: **April 30, 2014**

Facility response: Pressure Ulcer Champions review nursing documentation to ensure accuracy of pressure ulcer location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Compliance is reported to the Acute Care Associate Nurse Executive monthly and the Executive Committee of the Nursing Staff quarterly.

Recommendation 15. We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: **April 30, 2014**

Facility response: Pressure Ulcer Champions review nursing documentation to ensure acute care staff perform and document daily risk scales for patients at risk for or with pressure ulcers. Compliance is reported to the appropriate Acute Care Associate Nurse Executive monthly and the Executive Committee of the Nursing Staff quarterly.

Recommendation 16. We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections for all hospitalized patients identified as not being at risk for pressure ulcers and that compliance be monitored.

Concur

Target date for completion: **April 30, 2014**

Facility response: Pressure Ulcer Champions review nursing documentation to ensure that acute care staff performs and document daily skin inspections for all hospitalized patients identified as not being at risk for pressure ulcers. Compliance is reported to the Acute Care Associate Nurse Executive monthly and the Executive Committee of the Nursing Staff quarterly.

Recommendation 17. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: **April 30, 2014**

Facility response: The Pressure Ulcer Team reviews discharge documentation for evidence that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged utilizing the Skin/Wound Monitor. Compliance is reported to the appropriate Associate Nurse Executive monthly and the Executive Committee of the Nursing Staff quarterly.

Recommendation 18. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education to patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: **April 30, 2014**

Facility response: Pressure Ulcer Champions review nursing documentation monthly utilizing the Skin/Wound Monitor for evidence that patients and/or family/caregiver received pressure ulcer education for patients at risk for and with pressure ulcers. Compliance will be reported to the Acute Care Associate Nurse Executive monthly and to the Executive Committee of the Nursing Staff quarterly by the Quality Analyst of Acute Care Services.

Recommendation 19. We recommended that processes be strengthened to ensure that all employees who perform restorative nursing services receive training on and competency assessment for ROM and resident transfers.

Concur

Target date for completion: **February 28, 2014**

Facility response: Training and competency assessments of range-of-motion (ROM) and safe resident transfer for all staff will be provided and completed on February 28, 2014.

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.
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- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
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- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
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- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
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- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] 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.

[6] 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.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
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- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
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