Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04215-99

Combined Assessment Program Review of the Cincinnati VA Medical Center Cincinnati, Ohio

February 4, 2015

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
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Cincinnati VA Medical Center
FY	fiscal year
ICU	intensive care unit
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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 October 20, 2014.

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

- Magnetic Resonance Imaging Safety
- Acute Ischemic Stroke Care
- Emergency Airway Management

The facility's reported accomplishments were receipt of a 2014 Federal Service Excellence Award for the Hospital-In-Home program and local implementation of the national telemedicine intensive care unit program.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure licensed independent practitioners' privileging folders do not contain licensure verification information.

Environment of Care: Store clean and dirty items separately. Protect computer monitors from public viewing on the medical and surgical units.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

Coordination of Care: Designate a committee to oversee consult management. Ensure Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package.

Surgical Complexity: Revise the Radiology Service computed tomography scan and magnetic resonance imaging on-call policy to require a 30-minute reporting time. Ensure post-anesthesia care competency assessment and validation is completed for employees on the surgical intensive care unit.

Mental Health Residential Rehabilitation Treatment Program: Ensure Domiciliary Care for Homeless Veterans and Post-Traumatic Stress Disorder Program employees conduct and document monthly self-inspections.

Comments

The Veterans Integrated Service Network and Acting Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 29–33, 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 nine activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- 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 2014 and FY 2015 through October 20, 2014, 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 Cincinnati VA Medical Center, Cincinnati, Ohio,* Report No. 11-03666-79, February 13, 2012).

During this review, we presented crime awareness briefings for 102 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 624 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

Hospital-In-Home Program

On April 17, 2014, the Greater Cincinnati Federal Executive Board presented the facility's Hospital-In-Home program with a Federal Service Excellence Award for Outstanding Project Team.

The Hospital-In-Home program provides advanced, intensive therapy to patients in their homes and helps reduce both readmission rates and the number of days a patient stays in the hospital. In addition, the program provides a solution to hospital bed shortage. Patients who qualify medically for the program and agree to participate receive daily visits from a nurse and regularly communicate with their physician. The use of computerized video telehealth is being initiated, which will make face-to-face doctor visits possible.

In its first year, the Hospital-In-Home program helped reduce the congestive heart failure readmission rate by more than 20 percent and helped the facility save an estimated $1 million. Additionally, the patient satisfaction rate has consistently been between 95 and 100 percent.

National Telemedicine ICU Program

The telemedicine ICU program uses a combination of technologies, such as audiovisual communication, EHRs, sophisticated computer systems, and patient monitoring technology, to create a link between the facility and other ICUs in VISNs 7 and 10. The

program allows constant monitoring of critically ill patients even when the local nurses and doctors are out of the room assisting other critically ill patients.

Facility nurses and doctors with specialized training in critical care medicine staff the program 365 days a year, 24 hours per day. They have access to remote data such as vital signs, electrocardiograms, and EHRs. They are also able to speak with the patients, doctors, and nurses at the remote facility via video conferencing technology. Facility staff can directly intervene or consult with remote medical staff. The telemedicine ICU program is not meant as a replacement for the doctors and nurses caring for the patients at the remote site. It enhances patient care by encouraging adherence to critical care guidelines, augments bedside teaching for residents and medical students, and elevates the level of critical care services provided to veteran patients throughout the two VISNs, which have a total of 11 hospitals, 16 ICUs, and 197 ICU beds.

Results and Recommendations

QM

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

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The facility gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

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

EOC

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

We inspected the primary care clinic, the Emergency Department, the locked MH unit, medical (6N) and surgical (5N) units, medical and surgical ICUs, and the CLC. We also performed a perimeter inspection of the respiratory therapy room construction site in 5N. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 30 employee training records (20 critical care and 10 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met infection prevention requirements.	• One of five patient care areas had clean and dirty items stored together.	**2.** We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.
	The facility met medication safety and security requirements.		
X	The facility met privacy requirements.	• The positioning of computer monitors on the medical and surgical units did not restrict public viewing.	**3.** We recommended that the facility appropriately protect computer monitors from public viewing on the medical and surgical units and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met patient privacy requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
X	The facility met infection prevention requirements in the CLC.	• Dirty wheelchairs and a soiled shower litter were stored in the clean equipment storage room.	See recommendation 2.
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

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

Medication Management

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for users.	**4.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		

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

Coordination of Care

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

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 32 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	A committee oversaw the facility's consult management processes.	• The facility did not have a committee to oversee consult management.	**5.** We recommended that the facility designate a committee to oversee consult management.
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	• The Automated Data Processing Applications Coordinators did not provide training in the use of the computerized consult package.	**6.** We recommended that the Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 37 employees (30 randomly selected Level 1 ancillary staff and 7 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.		
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 30 randomly selected patients who experienced stroke symptoms, and 30 employee training records (5 Emergency Department, 5 medical ICU, 5 surgical ICU, and 15 medical and surgical unit), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, two critical care units, and three medical and surgical units. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility's stroke policy addressed all required items.		
	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.		
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
	Clinicians provided printed stroke education to patients upon discharge.		
	The facility provided training to employees involved in assessing and treating stroke patients.		

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NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility collected and reported required data related to stroke care.		
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

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

We reviewed relevant documents and the training records of 60 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	• Radiology Service's policy did not clearly specify that employees on call for computed tomography scans and MRI must report within 30 minutes.	**7.** We recommended that Radiology Service revise the computed tomography scan and magnetic resonance imaging on-call policy to require a 30-minute reporting time.
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Two of the three applicable employees on the surgical ICU did not have post-anesthesia care competency assessment and validation documentation completed.	**8.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the surgical intensive care unit.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

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

We reviewed relevant documents, including competency assessment documentation of 10 clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans and the Post-Traumatic Stress Disorder Programs complied with selected EOC requirements.[i]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans and the Post-Traumatic Stress Disorder Programs, 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.

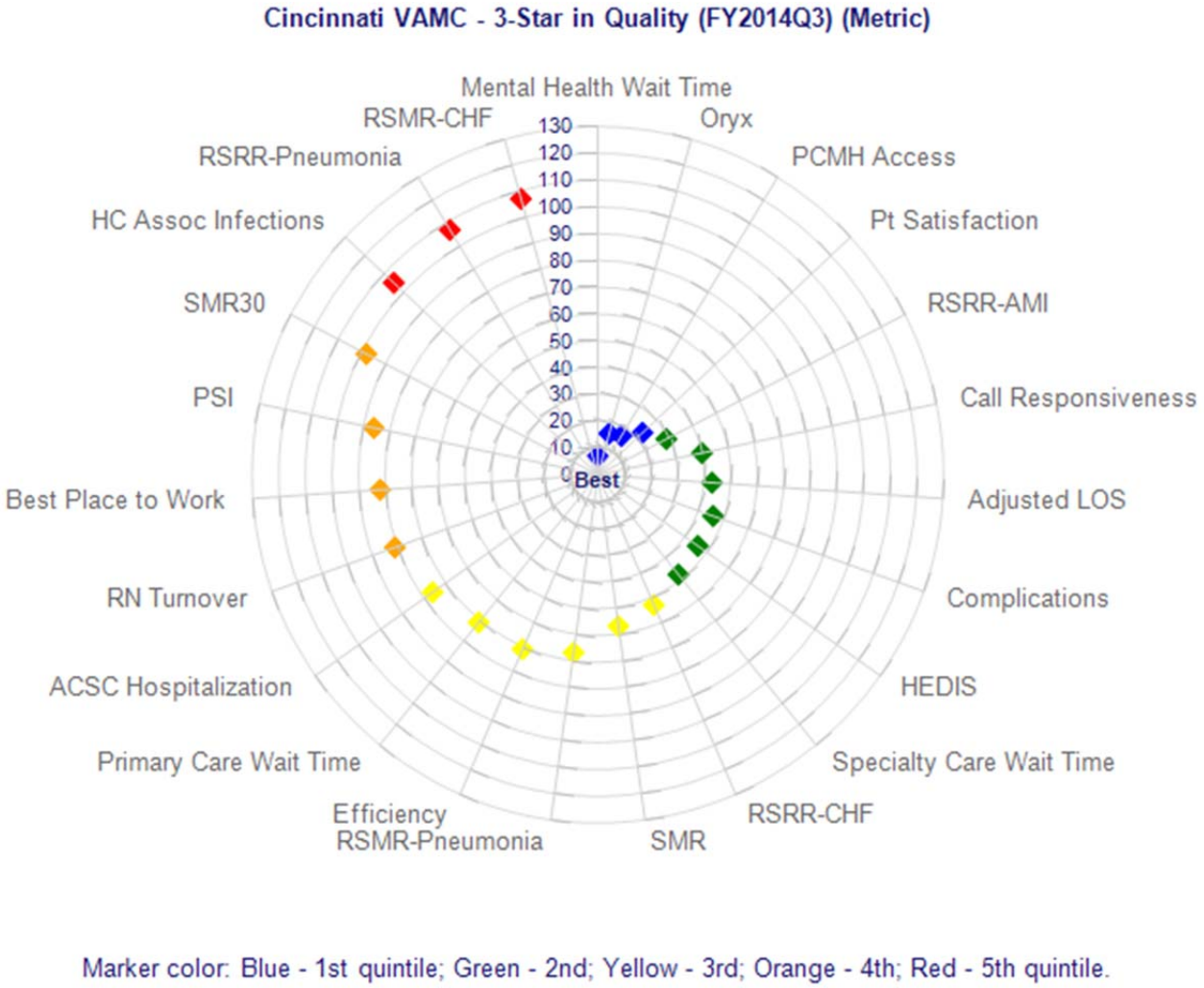
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	• We did not find documentation of any monthly self-inspections.	**9.** We recommended that Domiciliary Care for Homeless Veterans and Post-Traumatic Stress Disorder Program employees conduct and document monthly self-inspections and that program managers monitor compliance.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Cincinnati/539) FY 2014[1]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$375.1
Number of:	
• **Unique Patients**	43,412
• **Outpatient Visits**	597,989
• **Unique Employees**[2]	1,902
Type and Number of Operating Beds (as of August):	
• **Hospital**	117
• **CLC**	64
• **MH**	107
Average Daily Census (as of August):	
• **Hospital**	85
• **CLC**	50
• **MH**	93
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Bellevue/539GA Clermont County/539GB Lawrenceburg (Dearborn)/539GC Florence/539GD Hamilton/539GE Georgetown/539GF
VISN Number	10

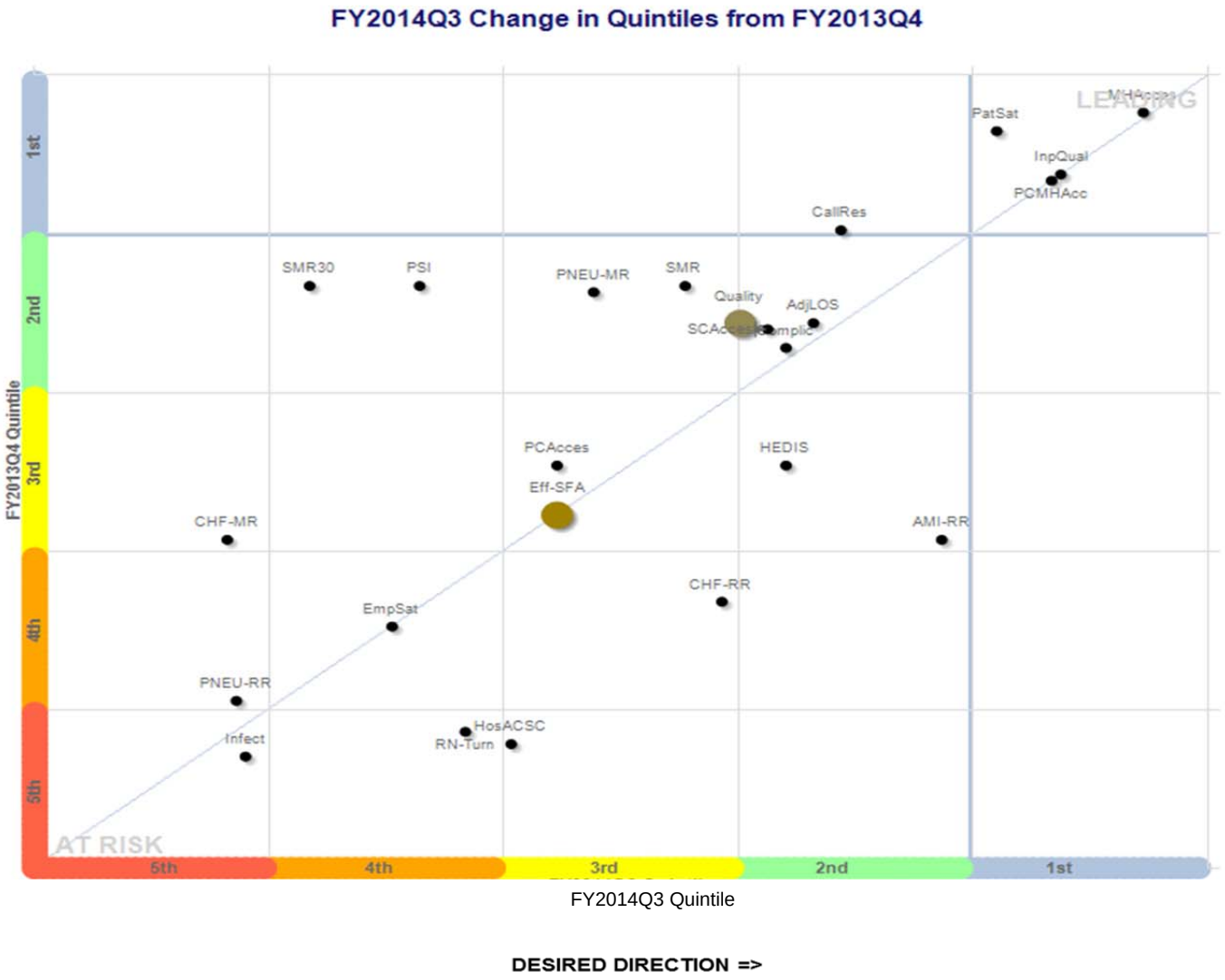
[1] All data is for the entire FY except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 7, 2015

From: Director, VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Cincinnati VA Medical Center, Cincinnati, OH**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

1. I have reviewed the recommendations and concur with responses and action plans submitted by the Cincinnati VA Medical Center.

2. If you have questions or require additional information, please contact Ms. Jane Johnson, VISN 10 Acting Deputy Network Director at (513) 247-4631.

(original signed by:)
Jack G. Hetrick, FACHE
Director, VA Healthcare System of Ohio (10N10)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 7, 2015

From: Acting Director, Cincinnati VA Medical Center (539/00)

Subject: **CAP Review of the Cincinnati VA Medical Center, Cincinnati, OH**

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

1. Attached please find the Cincinnati VA Medical Center responses and relevant action plan for the 9 recommendations from the Office of the Inspector General Combined Assessment Program Review conducted October 20–24, 2014.

2. We appreciate the professionalism demonstrated by the OIG CAP Team and the consultative attitude demonstrated during the review process.

3. If you have any questions regarding this report, please contact Lisa Veite, Cincinnati VA Medical Center Accreditation Specialist, at 513-861-3100, extension 5249.

(original signed by:)
Acting Director David Ninneman

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility ensure that licensed independent practitioners' folders do not contain licensure verification information.

Concur

Target date for completion: 1/16/2015

Facility response: Licensure verification will no longer be maintained in independent practitioners' folders. All licensure verifications will be removed from each independent practitioner's folder.

Recommendation 2. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: The shower litter was removed from the CLC. Dirty equipment has been removed from clean storage areas. Clean and dirty items are being stored separately. Compliance will be monitored by designated CLC and 6N managers.

Recommendation 3. We recommended that the facility appropriately protect computer monitors from public viewing on the medical and surgical units and that facility managers monitor compliance.

Concur

Target date for completion: 4/30/2015

Facility response: An inventory has been taken on the medical and surgical units for needed privacy screens and an order is in process. The privacy screens will be installed on the monitors once the order is received. Compliance will be monitored by the facility Privacy Officer.

Recommendation 4. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility manager's monitor compliance.

Concur

Target date for completion: 12/23/2014

Facility response: An addendum to the Automated Dispensing System (ADS) Policy and Procedure was completed and communicated 12/23/2014 stating that all users will be trained on the use of the ADS as part of the orientation process. Competency will be assessed by the supervisors through the existing monitoring of ADS reports for inappropriate or inconsistent use by users.

Recommendation 5. We recommended that the facility designate a committee to oversee consult management.

Concur

Target date for completion: 12/23/2014

Facility response: The Accelerated Care Initiative Committee has been designated to oversee consult management. This committee was initiated and began oversight of consult management October 14, 2014 as part of their charge. The committee meets monthly.

Recommendation 6. We recommended that the Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.

Concur

Target date for completion: 6/30/2015

Facility response: The Office of Information Technology (OIT) will coordinate training with Automated Data Processing Application Coordinators in the use of computerized consult package. Compliance will be monitored by the OIT manager.

Recommendation 7. We recommended that Radiology Service revise the computed tomography scan and magnetic resonance imaging on-call policy to require a 30-minute reporting time.

Concur

Target date for completion: 1/7/2015

Facility response: Radiology revised the on-call process to incorporate a 30 minute reporting time for computed tomography scan and magnetic resonance. Radiology also

developed a Standard Operating Procedure (SOP) entitled Radiology On Call and Call Back which incorporates the required 30-minute reporting time.

Recommendation 8. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the surgical intensive care unit.

Concur

Target date for completion: 1/5/2015

Facility response: All twenty-one employees in the surgical intensive care unit who have completed orientation have completed the post-anesthesia care competency assessment and validation. The Surgical Intensive Care Unit skill assessment/verification orientation record has been revised with specific post-anesthesia care skill assessments included.

Recommendation 9. We recommended that Domiciliary Care for Homeless Veterans and Post-Traumatic Stress Disorder Program employees conduct and document monthly self-inspections and that program managers monitor compliance.

Concur

Target date for completion: 3/31/2015

Facility response: As of October 31, 2014 the Domiciliary Care of Homeless Veterans and the Post Traumatic Stress Disorder programs are conducting and documenting monthly self-inspection. Compliance will be monitored by the Nurse Manager at the Ft. Thomas division.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

Endnotes

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

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

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

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

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

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

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

[i] References used for this topic were:
- 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 the National Fire Protection Association.