Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00073-200

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

April 9, 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	Dayton 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 February 2, 2015.

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

- Coordination of Care

The facility's reported accomplishment was the integration of Relationship Based Care principles throughout the facility.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Ensure the Special Care Unit Committee reviews each code episode. Require the Surgical Quality Council to meet monthly, document its review of National Surgical Office reports, and review all surgical deaths with identified problems or opportunities for improvement.

Environment of Care: Store clean and dirty items separately.

Medication Management: Use special medication labeling and unique storage practices for look-alike and sound-alike medications. Complete monthly medication storage area inspections. Consistently implement corrective actions for issues identified during monthly medication storage area inspections, and monitor the changes until issues are fully resolved. Revise the policy for safe use of automated dispensing machines to include required elements.

Magnetic Resonance Imaging Safety: Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution of all identified magnetic resonance imaging contraindications prior to the scan.

*Acute Ischemic Stroke Care: C*omplete and document National Institutes of Health stroke scales for each stroke patient. Provide printed stroke education to patients upon discharge.

Surgical Complexity: Revise local policies to require that radiology interpretation and computerized tomography coverage be available on call within 30 minutes. Ensure post-anesthesia care competency assessment and validation is completed for employees on the intensive care unit.

Emergency Airway Management: Initiate actions to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and if this does occur, initiate a root cause analysis.

Mental Health Residential Rehabilitation Treatment Program: Include all required elements in monthly inspections. Ensure the programs have written agreements in place acknowledging resident responsibility for medication security.

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 28–35, 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 February 5, 2015, 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 Dayton VA Medical Center, Dayton, Ohio,* Report No. 13-00278-164, April 4, 2013).

During this review, we presented crime awareness briefings for 422 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 375 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 Accomplishment

Relationship Based Care

All community based outpatient clinic, inpatient, outpatient, and support services participate in a Unit Practice Council dedicated to integrating the principles of Relationship Based Care throughout the facility. Over the past 4 years, 1,204 facility employees have attended a 3-day "Reigniting the Spirt of Caring" program, and 14 facility employees are certified as "Reigniting the Spirit of Caring" facilitators. The facility also developed a leadership program to deepen the understanding and commitment of service chiefs, managers, and supervisors to Relationship Based Care and the Unit Practice Council. Additionally, Friday's morning report includes discussion of a "Relationship Based Care Moment," demonstrating the Facility Director's commitment to the program.

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 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
	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
	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.		
	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.		
X	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.	Twelve months of Special Care Unit Committee meeting minutes reviewed: • The committee did not review each episode.	**1.** We recommended that the Special Care Unit Committee review each code episode.

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Quality Council only met nine times over the past 12 months. Nine months of Surgical Quality Council meeting minutes reviewed: • The council did not review National Surgical Office reports. Several surgical deaths that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • The Surgical Quality Council only reviewed one of these deaths.	**2.** We recommended that the Surgical Quality Council meet monthly and document its review of National Surgical Office reports. **3.** We recommended that the Surgical Quality Council review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee 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, senior managers actively participated in performance improvement over the past 12 months.		
	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 medical inpatient, surgical/medical inpatient, MH inpatient, CLC/rehabilitation, and transitional care units; the ICU; the Emergency Department; primary care clinics; and two CLCs (5N and Pod B). Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 48 employee training records (24 critical care and 24 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.	• Two of six patient care areas had clean and dirty items stored together.	**4.** 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.		
	The facility met privacy requirements.		
	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 blood borne 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.		
X	The facility met infection prevention requirements in critical care.	• One of two critical care areas had clean and dirty items stored together.	See recommendation 4.
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received blood borne 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.		
NA	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.	• Both CLCs had clean and dirty items stored together.	See recommendation 4.
	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.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	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 30 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the CLCs (5N, 5S, NH1), the Emergency Department, the post-anesthesia care unit, and one medical inpatient unit 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 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
	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
X	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 did not adhere to local policy, which required the use of special medication labeling and unique storage practices for look-alike and sound-alike medications.	**5.** We recommended that the facility use special medication labeling and unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance.
	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.		
X	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.	• The operating room, CLCs (5N, 5S, NH1), surgical inpatient unit (4N), and ICU had one or more missed monthly medication storage area inspection. • The facility did not consistently implement corrective actions for issues identified during monthly medication storage area inspections.	**6.** We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance. **7.** We recommended that the facility consistently implement corrective actions for issues identified during monthly medication storage area inspections and that facility managers monitor the changes until issues are fully resolved.
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 oversight of overrides and employee training and minimum competency requirements for users.	**8.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	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 45 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. 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
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	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 43 employees (27 randomly selected Level 1 ancillary staff and 16 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 a physical inspection of the MRI area. 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 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.		
X	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.	• Eleven of the 15 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**9.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.
	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 44 patients who experienced stroke symptoms, and 30 employee training records (15 Emergency Department and 15 ICU), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, the ICU, and one medical inpatient unit. 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
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For nine of the 28 applicable patients, clinicians did not document evidence of completion of stroke scales.	**10.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	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.		
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 27 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**11.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided training to employees involved in assessing and treating stroke patients.		
	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 the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 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.	• Local policies required that radiology interpretation and computerized tomography coverage be available on call within 60 minutes instead of 30 minutes.	**12.** We recommended that facility managers revise local policies to require that radiology interpretation and computerized tomography coverage be available on call within 30 minutes.
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Five of 10 employees on the ICU did not have post-anesthesia care competency assessment and validation documentation completed.	**13.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the 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 the EAM coverage schedule for 30 selected dates from January 1 through June 30, 2014, and we conversed with key managers and 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 facility had a local EAM policy or had a documented exemption.		
NA	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		
NA	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
NA	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 or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	VHA policy reviewed, which allows for extraordinary circumstances when an individual with demonstrated competency in EAM is not available to perform EAM in the event of an emergency. If this occurs, the facility must conduct a root cause analysis to identify vulnerabilities and initiate appropriate actions to minimize a repeat occurrence. • The facility had four instances when a non-privileged clinician performed an intubation, and there was no documentation of a root cause analysis.	**14.** We recommended that facility managers initiate actions to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and if this does occur, facility managers initiate a root cause analysis.

MH RRTP

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

We reviewed relevant documents; inspected the Domiciliary Care for Homeless Veterans Program, general psychiatric RRTP, Substance Abuse RRTP, and Post-Traumatic Stress Disorder RRTP; and conversed with key 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.

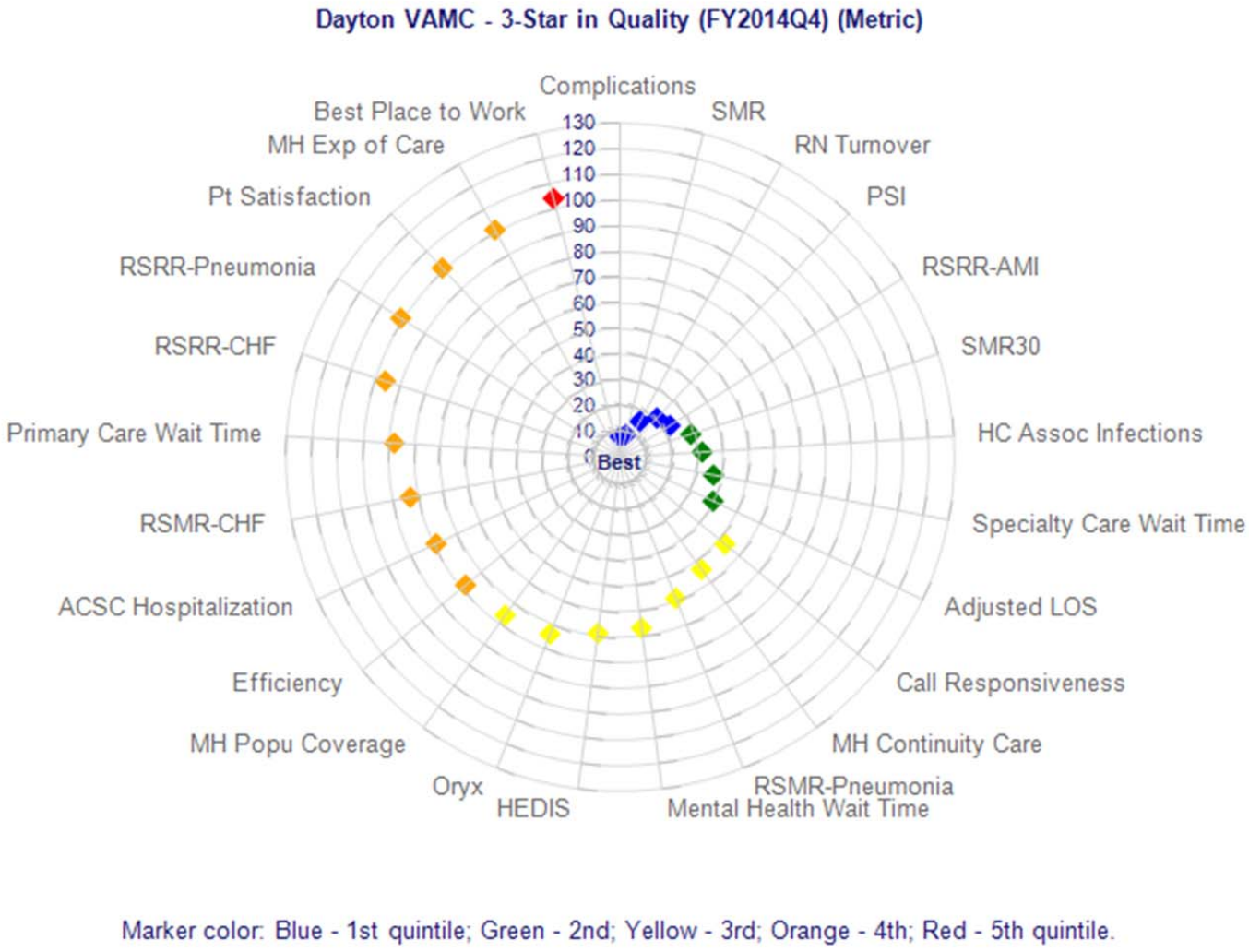
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH 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.	Six months of self-inspection documentation reviewed: • None of the inspections included documentation of all required elements.	**15.** We recommended that facility managers ensure that monthly inspections of the Mental Health Residential Rehabilitation Treatment Programs include all required elements.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
X	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.	Twelve resident medication security agreements requested: • Two residents did not have written agreements in place.	**16.** We recommended that Mental Health Residential Rehabilitation Treatment Program managers ensure that the programs have written agreements in place acknowledging resident responsibility for medication security.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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 (Dayton/552) FY 2015 through January 2015[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$320.9
Number (as of February 14, 2015) of:	
• **Unique Patients**	28,469
• **Outpatient Visits**	172,245
• **Unique Employees**[2]	1,822
Type and Number of Operating Beds:	
• **Hospital**	91
• **CLC**	225
• **MH**	80
Average Daily Census:	
• **Hospital**	59
• **CLC**	129
• **MH**	74
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Middletown/552GA Lima/552GB Richmond/552GC Springfield/552GD
VISN Number	10

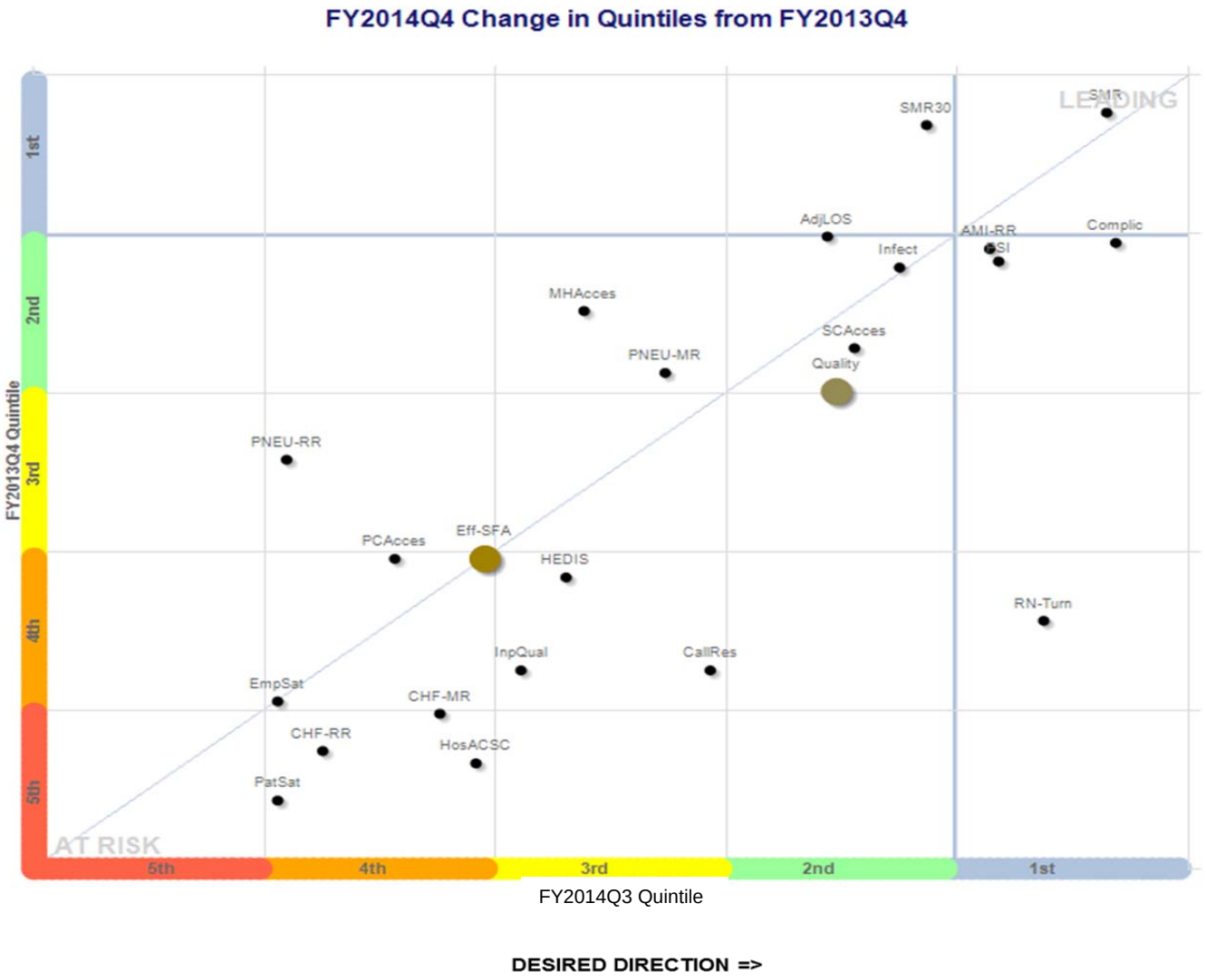
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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: March 25, 2015

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

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

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the draft report of the Combined Assessment Program Review of the Dayton VA Medical Center. I concur with the responses and action plans submitted by the Medical Center.

2. If you have any questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at 513-247-4631.

for J. Jane Johnson

for Jack G. Hetrick, FACHE
Network Director
VISN 10

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 25, 2015

From: Director, Dayton VA Medical Center (552/00)

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

To: Director, Baltimore Office of Healthcare Inspections (54BA)

1. Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio.

2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report.

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

4. If you have any questions, please contact Lisa Durham, Chief Quality Management Service, at 937-268-6511 extension 7630.

Glenn A. Costie, FACHE
Medical Center Director

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 Special Care Unit Committee review each code episode.

Concur

Target date for completion: October 1, 2015

Facility response: An interdisciplinary subcommittee of the Special Care Committee (SCU) comprised of an RN, Physician, Respiratory Therapist, and a Risk Management representative has been formed to review each episode of attempted resuscitation and review the information with the SCU Committee. Quality Management will perform a quarterly monitor to ensure each episode of attempted resuscitation was reviewed by the SCU committee. Sustained compliance for two (2) quarters will be achieved for closure.

Recommendation 2. We recommended that the Surgical Quality Council meet monthly and document its review of National Surgical Office reports.

Concur

Target date for completion: October 1, 2015

Facility response: The Surgical Quality Council will meet monthly on the first Thursday or a make-up meeting will be scheduled within the same month. The National Surgical Office quarterly report has been added to the monthly meeting agenda. Applicable details from the report will be presented at each meeting and documented in the meeting minutes. Sustained compliance for two (2) quarters will be achieved for closure.

Recommendation 3. We recommended that the Surgical Quality Council review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: June 1, 2015

Facility response: The Surgical Quality Council will review all surgical deaths. Surgical deaths with identified problems or opportunities for improvement will be discussed and action taken as deemed appropriate. These reviews have been added to the monthly

meeting agenda. Sustained compliance for two (2) months will be achieved for monitor closure.

Recommendation 4. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Dirty equipment has been removed from clean storage areas. Clean and dirty items are being stored separately. Re-education will be initiated by clinical unit leadership if needed. Nurse Manager will monitor the clean utility room weekly, at random times, to assure all items in the room are clean. Sustained compliance by unit for the two (2) months will be achieved for closure.

Recommendation 5. We recommended that the facility use special medication labeling and unique storage practices for look-alike and sound-alike medications and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Pharmacy Service will fully implement the use of special labeling (Tall Man lettering) on look-alike and sound-alike medications. The lettering will provide a visible reminder of medication in these categories. The Omni cell database is being updated to include this feature on all applicable medications. Also, these medications will only be stored and accessed in patient care areas using the Omni cell in order to utilize an additional look-alike and sound-alike alert feature. Pharmacy staff will monitor the look-alike and sound-alike medications to ensure the adherence of these new proper labeling and storage practices. Twenty-five (25) random audits of medication label(s) and/or Omni cell storage practices will be completed monthly. Sustained compliance >90% in consecutive months will need to be achieved for closure.

Recommendation 6. We recommended that facility managers ensure monthly medication storage area inspections are completed and monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Pharmacy Service will complete medication storage inspections in clinical areas monthly. Sustained compliance for two (2) months will be achieved for monitor closure in that area.

Recommendation 7. We recommended that the facility consistently implement corrective actions for issues identified during monthly medication storage area inspections and that facility managers monitor the changes until issues are fully resolved.

Concur

Target date for completion: July 1, 2015

Facility response: Pharmacy Service will ensure that corrective action is initiated for issues identified during the monthly medication storage inspections. Pharmacy Service will monitor the monthly inspection reports and ensure that corrective actions are fully resolved. Sustained compliance for two (2) months will be achieved for monitor closure in that area.

Recommendation 8. We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2015

Facility response: Pharmacy Service is developing a policy on the safe use of the automated dispensing machines. The policy will include oversight of overrides, employee training, and staff competency requirements. Pharmacy will monitor compliance to ensure that overrides, training and competencies are being managed in in accordance with the policy. Sustained compliance for two (2) months will be achieved for monitor closure.

Recommendation 9. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: The MRI patient screening document now contains an information section with a signature block for the Radiologist. The radiologist signature is validation that any MRI contraindication(s) have been researched, resolved, and the technologist may proceed with the MRI. This document will be scanned into the patient record prior to initiation of the procedure. Radiology will monitor ten (10) charts per month. Compliance > 90% in consecutive months, will be achieved for closure.

Recommendation 10. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Emergency Room Staff (RNs and providers) will be re-educated on the NIH stroke scale and expectation that it be completed when appropriate. Charts of Veterans admitted with a stroke diagnosis will be audited monthly. Sustained compliance >90% in consecutive months, will be achieved for closure.

Recommendation 11. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: The facility will ensure that Veterans with a stroke diagnosis are given printed stroke education documents prior to discharge from the facility. Inpatient Registered Nurses will be re-oriented to the American Heart Association (AHA) documents to provide and educated on the CPRS documentation requirements. Charts of Veterans admitted for stroke will be audited monthly. Sustained compliance >90% in consecutive months, will be achieved for closure.

Recommendation 12. We recommended that facility managers revise local policies to require that radiology interpretation and computerized tomography coverage be available on call within 30 minutes.

Concur

Target date for completion: October 1, 2015

Facility response: The facility is exploring VISN options to determine if one of our academic VISN partners can provide STAT interpretation coverage to meet the 30 minute requirement. Alternatively, we will explore local contract options (with our local commercial/private hospitals) for providing 30 minute STAT interpretations. If we are unable to partner with a VISN facility and cannot find a contract which enables us to meet the 30 minute imaging interpretation requirement, we will hire additional staff (3 additional imaging physicians) to cover 30 minute STAT interpretations in house. The facility plans to hire 4 additional technologists who will enable us to meet the 30 minute CT Tech response time requirement.

Recommendation 13. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the intensive care unit.

Concur

Target date for completion: April 1, 2015

Facility response: Nursing Service reviewed all ICU RN competencies to identify those missing the PACU (post-anesthesia care) competency assessment. Staff identified with this missing competency will complete and leadership will validate during March 2015. The post-anesthesia care competency is included in the annual list of ICU nurse competencies.

Recommendation 14. We recommended that facility managers initiate actions to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and if this does occur, facility managers initiate a root cause analysis.

Concur

Target date for completion: October 1, 2015

Facility response: Risk Management (RM) currently monitors all intubations related to codes and the provider who performs the intubation. Any episode in which RM becomes aware that a non-OORAM provider intubates will be immediately reported to the COS, Chief, Anesthesiology, and the Patient Safety Manager for initiation of a RCA. This information will also be included in the facility Resuscitation Report. Sustained compliance for two (2) quarters will be achieved for monitor closure.

Recommendation 15. We recommended that facility managers ensure that monthly inspections of the Mental Health Residential Rehabilitation Treatment Programs include all required elements.

Concur

Target date for completion: June 1, 2015

Facility response: The Mental Health Residential Rehabilitation Treatment Program team has developed and incorporated a monthly inspection checklist. The new checklist includes all patient accessible areas of the MHRRTP (Building 410) and all the required elements. The new checklist has been implemented. Sustained compliance for three (3) months will be achieved for monitor closure.

Recommendation 16. We recommended that Mental Health Residential Rehabilitation Treatment Program managers ensure that the programs have written agreements in place acknowledging resident responsibility for medication security.

Concur

Target date for completion: June 1, 2015

Facility response: The MHRRTP Safe Medication Management policy was updated on February 26, 2015 and is applicable to all programs. Veterans must agree in writing to comply with all MHRRTP medication security requirements. The Veteran reads and signs the consent statement. If the electronic IMED unit is not available, the nursing staff is being instructed to use a paper copy of the SMM for Veteran signature. The Veteran is given a copy of the signed consent statement and a copy is filed in the Veteran's record. The hard copy is sent to Medical Records to be scanned into the CPRS record.

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.