
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-00595-417**

# Combined Assessment Program Review of the Chillicothe VA Medical Center Chillicothe, Ohio

**July 10, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| AD | advance directive |
| CAP | Combined Assessment Program |
| CT | computed tomography |
| DRRTP | Domiciliary Residential Rehabilitation Treatment Program |
| EAM | emergency airway management |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Chillicothe VA Medical Center |
| FY | fiscal year |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| RRTP | residential rehabilitation treatment program |
| QM | quality management |
| SCI | spinal cord injury |
| VHA | Veterans Health Administration |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of April 6, 2015.

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

- Medication Management
- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishment was receiving the VA National Center for Patient Safety's Gold Cornerstone Award.

**Recommendations:** We made recommendations in the following six activities:

*Quality Management:* Ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training and that practitioner folders do not contain non-allowed information. Require Code Blue Committee code reviews to include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and document the screening reviews. Include Social Work and Chaplain Service and the Rehabilitation Medicine and Service Care Line in the review of electronic health record quality.

*Environment of Care:* Ensure that patient care areas are clean and in good repair and that areas under sinks are not used for storage.

*Coordination of Care:* Ensure that the recently implemented Consult Management Committee continues to meet regularly.

*Emergency Airway Management:* Ensure initial clinician emergency airway management competency assessment includes all required elements. Require that clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and includes all required elements.

*Mental Health Residential Rehabilitation Treatment Program:* Ensure the Domiciliary and Psychosocial Residential Rehabilitation Treatment Programs are clean. Require a Class K fire extinguisher to be available in the Domiciliary Residential Rehabilitation Treatment Program resident kitchen. Correct deficiencies identified during monthly Domiciliary Residential Rehabilitation Treatment Program self-inspections, and

document the corrections. Require that Domiciliary Residential Rehabilitation Treatment Program residents secure medications in their rooms.

*Suicide Prevention Program:* Ensure safety plans for all patients assessed to be at high risk for suicide specifically address suicidality.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 29–35 for the full text of the Directors' comments.) We consider recommendation 10 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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# Objectives and Scope

## Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

## Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- EAM
- MH RRTP
- Suicide Prevention Program

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 April 6, 2015, and inspectors conducted the review 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 Chillicothe VA Medical Center, Chillicothe, Ohio,* Report No. 13-00275-149, March 27, 2013.)

During this review, we presented crime awareness briefings for 84 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. We distributed an electronic survey to all facility employees and received 274 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

# Reported Accomplishment

## VA National Center for Patient Safety Cornerstone Recognition Program Award

The facility earned the VA National Center for Patient Safety's Gold Cornerstone Award. The Gold Award is the highest award given to a facility for improvements made in patient safety. The award recognizes the quantity and quality of the facility's root cause analyses and aggregate reviews. The focus of the award is timeliness, strength of actions, and reporting the impact of the actions taken as a result of the root cause analyses.

# 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, eight 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.<br>• The committee routinely reviewed aggregated data.<br>• QM, patient safety, and systems redesign appeared to be integrated. | | |
| | Peer reviewed deaths met selected requirements:<br>• Peers completed reviews within specified timeframes.<br>• The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings.<br>• 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:<br>• Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.<br>• Facility managers ensured appropriate privileges for licensed independent practitioners.<br>• Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation.<br>• Facility managers properly maintained licensed independent practitioners' folders. | • Of the eight licensed independent practitioners' folders reviewed, six practitioners' EAM privileges were not appropriate for their skills and training.<br>• Five of the eight licensed independent practitioners' folders contained non-allowed information. | **1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.<br>**2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information. |
| | Observation bed use met selected requirements:<br>• The facility gathered data regarding appropriateness of observation bed usage.<br>• 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:<br>• An interdisciplinary committee reviewed episodes of care where resuscitation was attempted.<br>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.<br>• The facility collected data that measured performance in responding to events. | Twelve months of Code Blue Committee meeting minutes reviewed:<br>• Code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code. | **3.** We recommended that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, that the committee document the screening reviews, and that facility managers monitor compliance. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | The surgical review process met selected requirements:<br>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.<br>• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement.<br>• The Surgical Work Group reviewed additional data elements. | | |
| | Clinicians appropriately reported critical incidents. | | |
| | The safe patient handling program met selected requirements:<br>• A committee provided program oversight.<br>• The committee gathered, tracked, and shared patient handling injury data. | | |
| X | The process to review the quality of entries in the EHR met selected requirements:<br>• A committee reviewed EHR quality.<br>• A committee analyzed data at least quarterly.<br>• Reviews included data from most services and program areas. | Twelve months of EHR Committee meeting minutes reviewed:<br>• The review of EHR quality did not include EHRs from Social Work Service, Chaplain Service, and the Rehabilitative Medicine and Service Care Line. | **4.** We recommended that the facility include Social Work Service, Chaplain Service, and the Rehabilitation Medicine and Service Care Line in the review of electronic health record quality. |
| | The policy for scanning internal forms into EHRs included the following required items:<br>• Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate.<br>• 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 emergency management.[b]

We inspected the acute MH and MH rehabilitation units; the medical and special care units; the community living center areas (210 and 211); the primary care, women veterans' health, podiatry, and gastrointestinal clinics; and the urgent care center. Additionally, we reviewed relevant documents, including 10 employee training and competency records, 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. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| | The facility met fire safety requirements. | | |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|---|---|---|---|
| X | The facility met environmental safety requirements. | The acute MH unit had the following environmental deficiencies:<br>• In a patient nourishment kitchenette, there was evidence of plumbing leaks, food spills, and splatters; the emergency suction equipment was dirty; and the cabinet under the patient kitchenette sink was dirty and contained food, hand sanitizer, and an unsecured cleaning product.<br>• A locked room for private use by patients and visitors had a full trash can and dirty bathroom fixtures.<br><br>The MH rehabilitation unit had the following environmental deficiencies:<br>• Two restrooms had offensive odors.<br>• Floor tiles were cracked or chipped throughout a hallway, and there was damage to flooring and walls below two drinking fountains.<br>• One patient room had an incomplete repair of a wall with previous water damage. | **5.** We recommended that facility managers ensure that patient care areas are clean and in good repair and that areas under sinks are not used for storage and monitor compliance. |
| | The facility met infection prevention requirements. | | |
| | 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. | | |

| NM | Areas Reviewed for SCI Center | Findings | Recommendations |
|---|---|---|---|
| NA | The facility completed and documented required inspection checklists of all ceiling mounted patient lifts. | | |
| NA | The facility met fire safety requirements in the SCI Center. | | |
| NA | The facility met environmental safety requirements in the SCI Center. | | |
| NA | The facility met infection prevention requirements in the SCI Center. | | |
| NA | The facility met medication safety and security requirements in the SCI Center. | | |
| NA | The facility met patient privacy requirements in the SCI Center. | | |
| NA | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Emergency Management** | | |
| | The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually. | | |
| | The facility maintained a list of resources and assets it may need during an emergency. | | |
| | The facility had a written Emergency Operations Plan that addressed key components. | | |
| | The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time. | | |
| | Employees received training and competency assessment on use of emergency evacuation devices. | | |

| NM | Areas Reviewed for Emergency Management (continued) | Findings | Recommendations |
|---|---|---|---|
| | Evacuation devices were immediately accessible and in good repair. | | |
| | 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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the medical unit, urgent care center, intensive care unit, and community living center (210) 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. 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 |
|---|---|---|---|
| | 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. | | |
| NA | 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. | | |
| | 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. | | |
| | 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. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | 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 47 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 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 |
|---|---|---|---|
| X | A committee oversaw the facility's consult management processes. | • Prior to January 2015, the facility did not have a committee to oversee consult management. | **6.** We recommended that the recently implemented Consult Management Committee continue to meet regularly to review consult data. |
| | Major bed services had designated employees to:<br>• Provide training in the use of the computerized consult package<br>• Review and manage consults. | | |
| | Consult requests met selected requirements:<br>• Requestors included the reason for the consult.<br>• Requestors selected the proper consult title.<br>• 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. | | |

## CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for five CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 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 |
|---|---|---|---|
| | The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program. | | |
| | The facility had a CT/imaging/radiation safety policy or procedure that included:<br>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance<br>• CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer<br>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols<br>• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | A radiologist, technologist expert in CT, and medical physicist reviewed all CT protocols revised during the past 12 months, and a medical physicist tested a sample of CT protocols at least annually. | | |
| | A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service. | | |
| | If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review, and any summary reports provided by teleradiology included dose information. | | |
| | CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification. | | |
| | There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring. | | |
| | If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for veterans.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 50 randomly selected patients who had an acute care admission January 1–December 31, 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 |
|---|---|---|---|
| | The facility had an AD policy that addressed:<br>• AD notification, screening, and discussions<br>• Proper use of AD note titles | | |
| | Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening. | | |
| | When patients provided copies of their current ADs, employees had scanned them into the EHR.<br>• Employees correctly posted patients' AD status. | | |
| | When inpatients requested a discussion about ADs (create, change, and/or revoke), employees:<br>• Documented the discussion<br>• Used the required AD note titles | | |
| | The facility met 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.[g]

We reviewed relevant documents, including competency assessment documentation of 12 clinicians applicable for the review period January 1–June 30, 2014, 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 |
|---|---|---|---|
| | 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:<br>• Competency assessment and reassessment processes<br>• Use of equipment to confirm proper placement of breathing tubes<br>• A plan for managing a difficult airway | | |
| X | Initial competency assessment for EAM included:<br>• Subject matter content elements and completion of a written test<br>• Successful demonstration of procedural skills on airway simulators or mannequins<br>• Successful demonstration of procedural skills on patients | • One of the two clinicians with initial EAM competency assessment did not have documentation of all required subject matter content elements, evidence of a completed written test, or evidence of successful demonstration of all required procedural skills on airway simulators or mannequins. | **7.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance. |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | | • Neither of the two clinicians with initial EAM competency assessment had evidence of successful demonstration of all required procedural skills on patients. | |
| X | Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included:<br>• Review of clinician-specific EAM data<br>• Subject matter content elements and completion of a written test<br>• Successful demonstration of procedural skills on airway simulators or mannequins<br>• 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<br>• A statement related to EAM if the clinician was not a licensed independent practitioner | • Five of the 10 applicable clinicians did not have reassessments for continued EAM competency completed at the time of renewal of privileges or scope of practice.<br>• Of the 10 clinicians with reassessments for continued EAM competency:<br>o Nine did not have documentation of all required subject matter content elements or evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.<br>o Six did not have evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluation superior at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert. | **8.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and includes all required elements and that facility managers monitor compliance. |
| | 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. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | 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 DRRTP and Psychosocial RRTP complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the DRRTP and Psychosocial 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 |
|---|---|---|---|
| X | The residential environment was clean and in good repair. | • The DRRTP had dirty shower basins, and the DRRTP and the Psychosocial RRTP had dirty chairs in the day and visitor rooms. | **9.** We recommended that facility managers ensure the Domiciliary and Psychosocial Residential Rehabilitation Treatment Programs are clean and monitor compliance. |
| X | Appropriate fire extinguishers were available near grease producing cooking devices. | • The DRRTP kitchen did not have a Class K fire extinguisher available. | **10.** We recommended that the Domiciliary Residential Rehabilitation Treatment Program have a Class K fire extinguisher available in the kitchen used by residents. |
| | 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. | Fourteen months of self-inspection documentation reviewed:<br>• Documentation did not reflect correction of 30 deficiencies identified in the DRRTP. | **11.** We recommended that the facility correct the deficiencies identified during monthly Domiciliary Residential Rehabilitation Treatment Program self-inspections and that documentation reflects correction. |
| | 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. | | |

| 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. | | |
| X | Residents secured medications in their rooms. | • Two resident rooms in the DRRTP contained unsecured medications. | **12.** We recommended that Domiciliary Residential Rehabilitation Treatment Program managers ensure residents secure medications in their rooms and monitor compliance. |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[i]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide and the training records of 15 new 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.

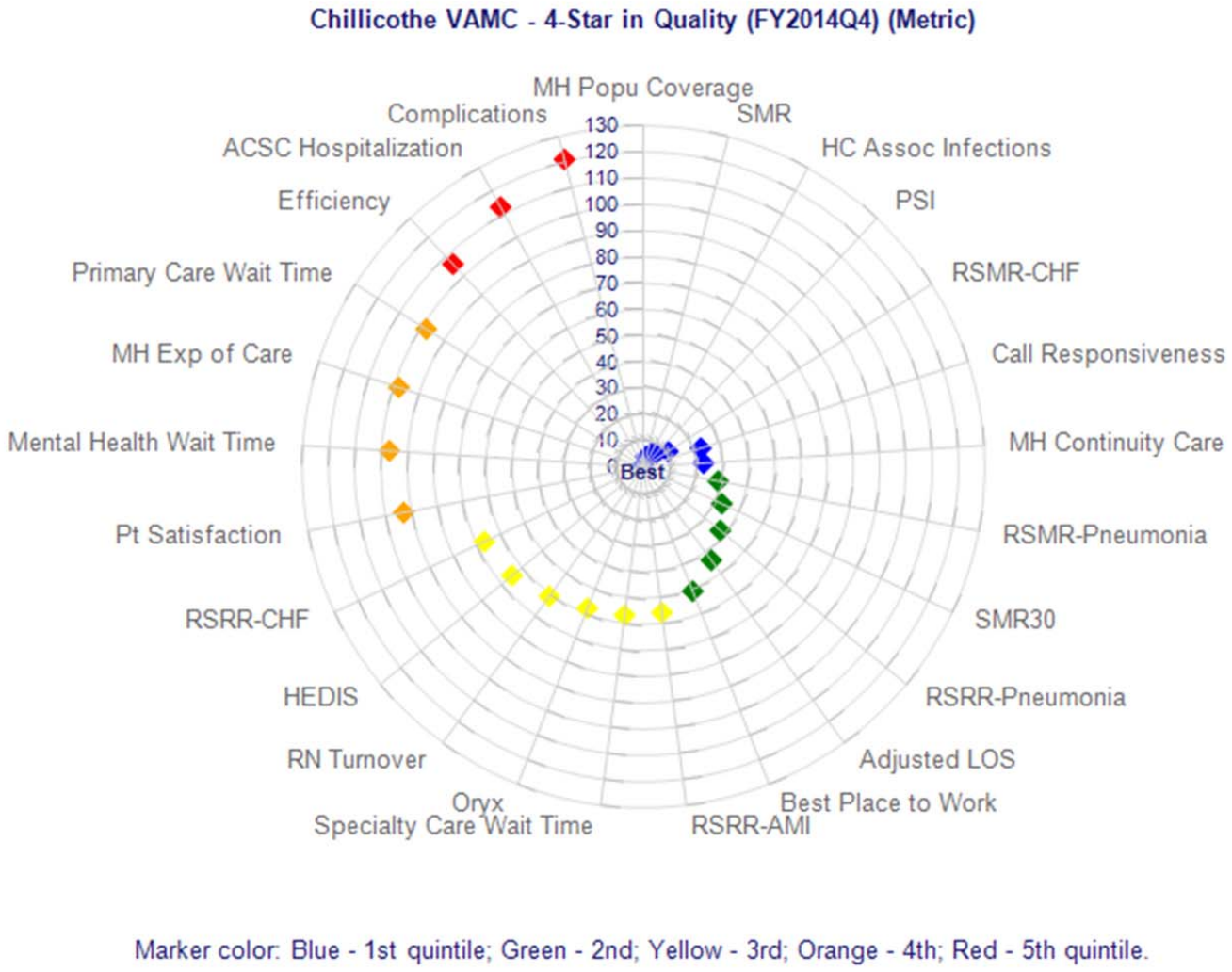
| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a full-time Suicide Prevention Coordinator and a plan for back-up. | | |
| | The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide. | | |
| | The facility provided suicide prevention training to new employees and community organizations. | | |
| | The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months. | | |
| | The facility had a process to follow up on patients who missed MH appointments. | | |
| X | Patients had documented safety plans that specifically addressed suicidality. | • In four EHRs (13 percent), safety plans did not specifically address suicidality. | **13.** We recommended that clinicians ensure that the safety plans for all patients assessed to be at high risk for suicide specifically address suicidality and that facility managers monitor compliance. |
| | Patients and/or their families participated in safety plan development. | | |
| | Clinicians documented safety plans that contained all required elements. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Clinicians documented that the patients and/or their families received a copy of the safety plan. | | |
| | Clinicians placed flags in the EHRs for high-risk patients. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

| Facility Profile (Chillicothe/538) FY 2015 through April 2015[1] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 2-Medium complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $187.9 |
| **Number (as of March) of:** | |
| • **Unique Patients** | 18,325 |
| • **Outpatient Visits** | 146,575 |
| • **Unique Employees**[2] | 1,038 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 63 |
| • **Community Living Center** | 162 |
| • **MH** | 78 |
| **Average Daily Census:** | |
| • **Hospital** | 39 |
| • **Community Living Center** | 145 |
| • **MH** | 67 |
| **Number of Community Based Outpatient Clinics** | 5 |
| **Location(s)/Station Number(s)** | Athens/538GA<br>Portsmouth/538GB<br>Marietta/538GC<br>Lancaster/538GD<br>Cambridge/538GE |
| **Veterans Integrated Service Network Number** | 10 |

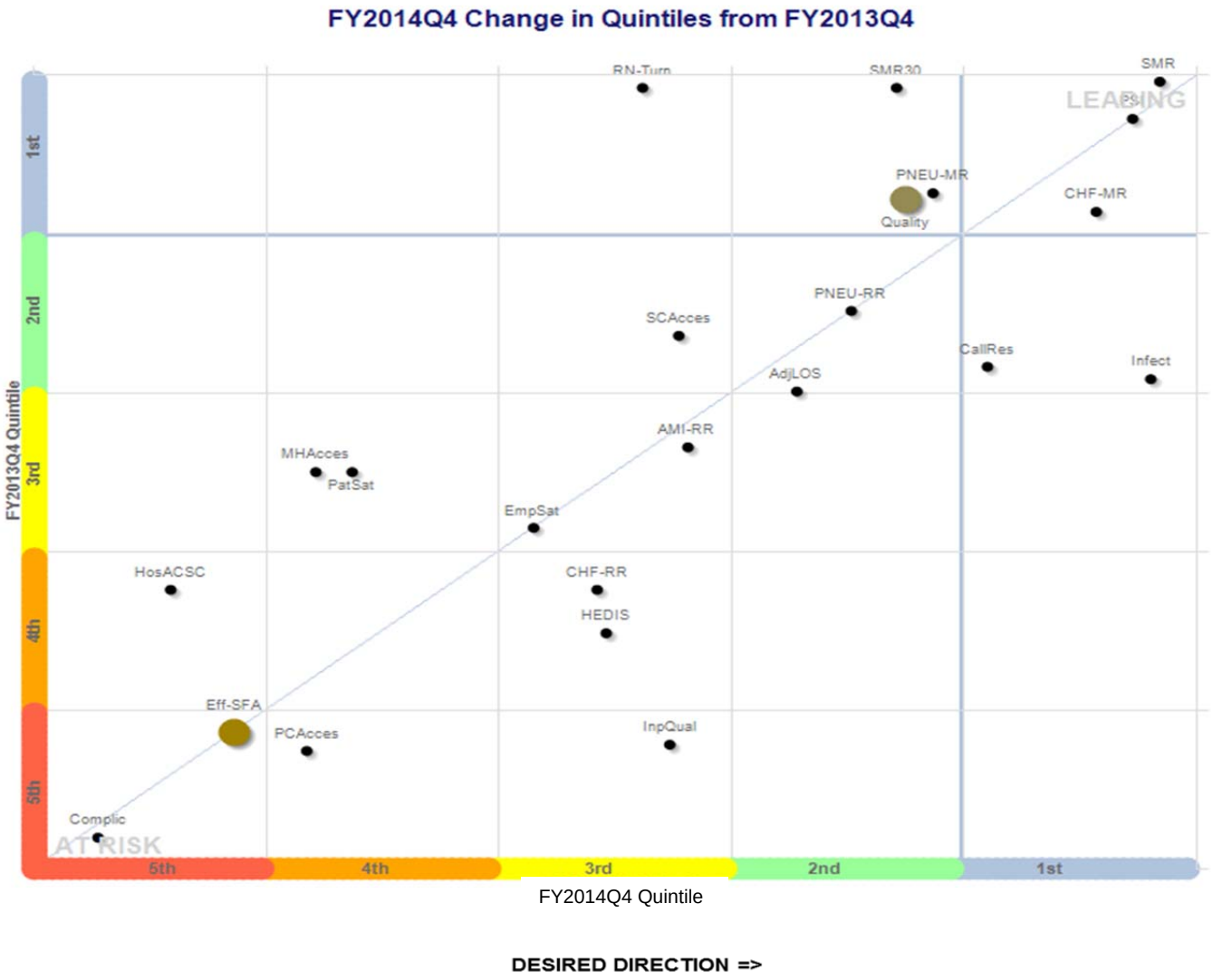
[1] All data is for FY 2015 through April 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

# 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 |

**Appendix C**

# Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** May 27, 2015

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

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

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

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

1. Attached, please find the comments and corrective action plan for the draft report of the Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, Ohio.

2. I have reviewed and concur with the responses and action plan submitted by the Medical Center.

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

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

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** May 27, 2015

**From:** Director, Chillicothe VA Medical Center (538/00)

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

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

1. Thank you for the opportunity to provide a response to the recommendations from the Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, OH.

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

3. If you have questions regarding our response or planned corrective action, please feel free to contact me at 740-772-7002.

*(original signed by:)*
Wendy J. Hepker, 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 facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: 10/1/2015

Facility response: New privilege forms that detail the correct requirements that must be met to qualify for endotracheal intubation have been approved and implemented. These forms apply to both initial appointments and reappraisals. Sustained compliance for 4 months will be achieved for monitor closure in that area.

**Recommendation 2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: 10/1/2015

Facility response: The Credentialing Counselor will ensure that licensed independent practitioners folders do not contain non-allowed information. As folders are processed for re-privileging or filing, Credentialing and Privileging staff will remove non-allowed information. Once current, a monthly audit of an appropriate sample size will be conducted to ensure there is no non-allowed information in licensed independent practitioner folders. Monthly audits will continue until three consecutive months of at least 90% compliance has been demonstrated.

**Recommendation 3.** We recommended that Code Blue Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, that the committee document the screening reviews, and that facility managers monitor compliance.

Concur

Target date for completion: 8/1/2015

Facility response: An amended de-briefing form which includes a field for clinical issues prior to the code has been approved and is currently accessible to staff for utilization. Clinical issues prior to the code will continue to be discussed during the CPR Committee bi-monthly meetings. Evidence of the form's usage and discussion of

clinical issues prior to the code will be monitored in meeting minutes for the next 2 meetings.

**Recommendation 4.** We recommended that the facility include Social Work Service, Chaplain Service, and the Rehabilitation Medicine and Service Care Line in the review of electronic health record quality.

Concur

Target date for completion: 12/1/15

Facility response: The Chief, Health Information Management Service (HIMS), will meet with the Chiefs of Social Work Services, Chaplain Service, and the Rehabilitative Care Line to review current monthly monitors to help identify and develop reports to be submitted to the Medical Records Committee. Service Chiefs will be educated on what data to submit, how data is to be submitted, the frequency data is to be submitted, and how data will be used for improvement. Audits will be implemented and continue until three consecutive months of at least 90% compliance has been demonstrated.

**Recommendation 5.** We recommended that facility managers ensure that patient care areas are clean and in good repair and that areas under sinks are not used for storage and monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: Areas identified by the OIG have been cleaned and repaired. Staff conducting regular EOC rounds will continue to assess areas in need of cleaning and/or repair. A risk-based approach will be used for prioritizing areas and in determining timeframes for tasks and cleaning. Areas will be identified based on risk from most critical to least critical patient care areas. Monthly audits by Collateral Duty Safety Officers will be implemented and continue until three consecutive months of compliance has been demonstrated.

**Recommendation 6.** We recommended that the recently implemented Consult Management Committee continue to meet regularly to review consult data.

Concur

Target date for completion: 12/30/2015

Facility response: The Consult Management Committee Charter was developed and implemented on 9/19/2014. Clinical services are well represented and a Committee Chair and Co-Chair are in place. The committee identifies and reviews important consult-related issues and develops plans and actions to address these concerns. This committee meets quarterly and at the call of the Chairperson. The committee will

continue to hold quarterly meetings this year, with a minimum of four meetings between January and December, 2015. The committee reports to the Quality Council.

**Recommendation 7.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: New privilege forms that detail the correct requirements that must be met to qualify for endotracheal intubation have been approved and implemented. These forms apply to both initial appointments and reappointments. Audits will be conducted on all applicable appointments/reappointments to ensure compliance. Sustained compliance for 3 months will be achieved for closure.

**Recommendation 8.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: New privilege forms that detail the correct requirements that must be met to qualify for endotracheal intubation have been approved and implemented. These forms apply to both initial appointments and reappraisals. Audits will be conducted on all applicable appointments/reappointments to ensure compliance. Sustained compliance for 3 months will be achieved for monitor closure in that area.

**Recommendation 9.** We recommended that facility managers ensure the Domiciliary and Psychosocial Residential Rehabilitation Treatment Programs are clean and monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: Areas and items identified by the OIG have been deep cleaned. DRRTP staff will enter work orders as items requiring cleaning or repairs are identified. Staff conducting regular EOC rounds will continue to monitor the DRRTP area for items needing cleaning or repair. DRRTP Nurse Manager will implement monthly audits which will continue until three consecutive months of at least 90% compliance has been demonstrated.

**Recommendation 10.** We recommended that the Domiciliary Residential Rehabilitation Treatment Program have a Class K fire extinguisher available in the kitchen used by residents.

Concur

Target date for completion: 4/15/2015

Facility response: A class K Fire Extinguisher is now installed in the DRRTP kitchen.

**Recommendation 11.** We recommended that the facility correct the deficiencies identified during monthly Domiciliary Residential Rehabilitation Treatment Program self-inspections and that documentation reflects correction.

Target date for completion: 10/1/2015

Facility response: The Chief, Environment Management Service, obtained the incomplete work orders identified by the OIG Team that were submitted by DRRTP staff and is in process of prioritizing addressing each work order. DRRTP Nurse Manager will implement monthly audits of work order implementation and completion which will continue until three consecutive months of at least 90% compliance has been demonstrated.

**Recommendation 12.** We recommended that Domiciliary Residential Rehabilitation Treatment Program managers ensure residents secure medications in their rooms and monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: In addition to existing safety and security checks performed by nursing staff on the Domiciliary, signs will be posted at unit exits reminding Veterans to ensure all medications are secured. Staff will also remind MHRRTP residents at the monthly Domiciliary Patient Government meetings to secure their medications. DRRTP Nurse Manager will implement monthly audits of medication security which will continue until three consecutive months of at least 90% compliance has been demonstrated.

**Recommendation 13.** We recommended that clinicians ensure that the safety plans for all patients assessed to be at high risk for suicide specifically address suicidality and that facility managers monitor compliance.

Concur

Target date for completion: 10/1/2015

Facility response: Safety plans will be posted next to the Category I Patient Record Flag Note and reposted at the time of every Patient Record Flag renewal. The

Veteran's outpatient mental health provider will be notified of any missing safety plans or safety plans not addressing suicidality. Missing safety plans or plans needing improvement will be addressed. The updated safety plan will be provided to the Veteran to replace the initial safety plan or to provide the Veteran with an initial safety plan. The Suicide Prevention Coordinator will implement monthly audits of this process which will continue until three consecutive months of at least 90% compliance has been demonstrated.

# Office of Inspector General
# Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
| **Inspection Team** | Bruce Barnes, Team Leader<br>Lisa Barnes, MSW<br>Gail Bozzelli, RN<br>Myra Conway, MSN<br>Kay Foster, RN<br>Donna Giroux, RN<br>Randall Snow, JD<br>Gavin McClaren, Resident Agent in Charge, Office of Investigations |
| **Other Contributors** | Elizabeth Bullock<br>Shirley Carlile, BA<br>Paula Chapman, CTRS<br>Lin Clegg, PhD<br>Marnette Dhooghe, MS<br>Natalie Sadow, MBA<br>Julie Watrous, RN, MS<br>Jarvis Yu, MS |

# Report Distribution

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Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, Rob Portman
U.S. House of Representatives: Steve Chabot, Bill Johnson, Steve Stivers, Michael Turner, Brad Wenstrup

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 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[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 Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] 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.

[h] 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.

[i] References used for this topic included:

- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of The Joint Commission.