Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04694-80

Combined Assessment Program Review of the Chalmers P. Wylie VA Ambulatory Care Center Columbus, Ohio

January 14, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CS	controlled substances
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Chalmers P. Wylie VA Ambulatory Care Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
QSV	quality, safety, and value
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 November 2, 2015.

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

- Medication Management – Controlled Substances Inspection Program
- Continuity of Care
- Management of Workplace Violence

The facility's reported accomplishments were mental health evidence-based treatment and Veterans Health Administration survey results.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Implement a consistent Ongoing Professional Practice Evaluation process.

Environment of Care: Ensure patient care areas are clean. Repair damaged furniture in patient care areas, or remove it from service, and repair damaged walls. Repair or replace damaged vinyl floor tiles and heavily soiled, torn, and frayed carpeting in patient care areas. Clean wheelchairs used by patients and visitors.

Medication Management – Compounded Sterile Products: Include in policy the frequency of competency assessment requirements for employees who prepare compounded sterile products. Establish compounded sterile products competency assessment requirements for pharmacists. Ensure pharmacy employees who prepare compounded sterile products complete all competency components annually. Revise the compounded sterile products safety/competency assessment checklist to include all required elements. Ensure employees who compound sterile products don all required personal protective equipment in the ante area prior to entering the IV Prep Room. Ensure the IV Prep Room has sterile chemotherapy-type gloves available for compounding hazardous medications. Perform and document daily floor cleaning in the compounding area.

Computed Tomography Radiation Monitoring: Follow up on computed tomography scanners that fail annual inspection by the medical physicist. Require that a medical physicist inspects computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service, and document the inspection.

Mammography Services: Link mammogram results to the radiology order in the electronic health record.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within 90 days of being hired. Do not place flags in the electronic health records of moderate- and low-risk patients. Include in Suicide Prevention Safety Plans an assessment of available lethal means and how to keep the environment safe.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 29–38, 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
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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:

- QSV
- EOC
- Medication Management – CSPs
- Medication Management – CS Inspection Program
- Continuity of Care
- CT Radiation Monitoring
- Mammography Services
- Suicide Prevention Program
- Management of Workplace Violence

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 2015 and FY 2016 through November 5, 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 Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio,* Report No. 13-02638-01, October 28, 2013.

During this review, we presented crime awareness briefings for 140 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 238 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 Accomplishments

MH Evidence-Based Treatment

Currently, seven of the facility's MH professionals serve as national evidence-based treatment consultants, and the facility offers several evidence-based MH treatment programs. For example, for patients referred for post-traumatic stress disorder (PTSD) treatment, employees offer evidence-based treatment as well as other group, family, and individual treatments, which are based on the patient's unique needs and preferences. The facility also implemented Integrative Dual Diagnosis Treatment for patients with co-occurring severe mental illness and substance use disorders and in the first 2 years of implementation, reduced inpatient MH admissions from 46 to zero for program participants.

VHA Survey Results

In FY 2015, facility nurses ranked the highest in job satisfaction on the annual VHA National Nursing Work Index – Practice Environment Scale Survey. Additionally, facility scores on the applicable Integrated Ethics Staff Survey were the highest in VISN 10. In 42 of 46 questions, facility scores exceeded VHA's national average, and the facility ranked first in VISN 10 and 18th nationally as an Ethical Organization. The facility excelled in the Culture of Safety component in the most recent Voice of the Veteran Survey, scoring highest amongst VHA facilities in 14 of the 15 Culture of Safety items.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, five root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' OPPE data. • Facility clinical managers reviewed OPPE data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Nineteen of 20 licensed independent practitioners did not have OPPE profiles.	**1.** We recommended that the facility implement a consistent Ongoing Professional Practice Evaluation process.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
NA	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.		
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	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 the dental clinic.[b]

We inspected the extended care/geriatric, general surgery/wound care, primary care, urology, dental, MH, and women's clinics; neurology/physical medicine and rehabilitation; radiology; surgical services; and the urgent care center. Additionally, we reviewed relevant documents and 10 dental clinic employee training records, and we conversed with key employees and managers. 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 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 between patients.		
NA	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Of the 10 patient care areas: o Four had dirty floors. o Two contained damaged furniture, and two had damaged walls. o One had damaged vinyl floor tiles and posed a tripping hazard, and one had heavily soiled, torn, and frayed carpeting. • The main lobby had dusty and dirty floors. • There were dirty wheelchairs at the main lobby entrance and in three patient care areas.	**2.** We recommended that facility managers ensure patient care areas are clean and monitor compliance. **3.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service and repair damaged walls. **4.** We recommended that the facility repair or replace damaged vinyl floor tiles and heavily soiled, torn, and frayed carpeting in patient care areas. **5.** We recommended that facility managers ensure wheelchairs used by patients and visitors are clean 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.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management – CSPs

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (six pharmacists and four technicians). Additionally, we inspected the area where sterile products are compounded. 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 policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Facility policy did not address the frequency of competency assessment requirements for employees who prepare CSPs. • The facility had not established CSP competency assessment requirements for pharmacists. • Pharmacy employees who prepare CSPs did not have all competency assessment components completed annually.	**6.** We recommended that facility policy include the frequency of competency assessment requirements for employees who prepare compounded sterile products. **7.** We recommended that pharmacy managers establish compounded sterile products competency assessment requirements for pharmacists. **8.** We recommended that pharmacy managers ensure pharmacy employees who prepare compounded sterile products complete all competency components annually and monitor compliance.
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding CS		
X	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.	• The facility's CSP safety/competency assessment checklist did not include: o Donning personal protective equipment in a required order o Buffer area safety steps o Verification of all finished CSPs by a pharmacist o Performance of appropriate hand hygiene in the ante room after personal protective equipment removal	**9.** We recommended that the facility revise the compounded sterile products safety/competency assessment checklist to include all required elements.

NM	Areas Reviewed (continued)	Findings	Recommendations
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
X	The facility met design and environmental safety controls in compounding areas.	• Employees did not don all required personal protective equipment in the ante area prior to entering the IV Prep Room.	**10.** We recommended that pharmacy managers ensure employees who prepare compounded sterile products don all required personal protective equipment in the ante area prior to entering the IV Prep Room and monitor compliance.
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
X	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.	• The IV Prep Room did not have sterile chemotherapy-type gloves available for compounding hazardous medications.	**11.** We recommended that pharmacy managers ensure the IV Prep Room has sterile chemotherapy-type gloves available for compounding hazardous medications and monitor compliance.
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• There was no documented evidence of daily floor cleaning in the compounding area.	**12.** We recommended that facility managers ensure employees perform and document daily floor cleaning in the compounding area and monitor compliance.
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management – CS Inspection Program

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

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and six CS inspectors and inspection documentation from 10 CS areas, the pharmacy, and the emergency drug cache. 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 was consistent with VHA requirements.		
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies.		
	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.		
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the Facility Director.		
	The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest.		
	The Facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.		
	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.		
	The facility complied with any additional elements required by VHA or local policy.		

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.[e]

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community September 1, 2014, through August 8, 2015. 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
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.		
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.		
	The facility complied with 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.[f]

We reviewed relevant documents, including qualifications and dosimetry monitoring for five CT technologists and CT scanner inspection reports, and 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. 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 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: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • 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 • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
X	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.	• One of two CT scanners failed the annual inspection by the medical physicist. • One of two CT scanners that had repairs or modifications that affected dose or image quality did not receive an inspection by a medical physicist before return to clinical service.	**13.** We recommended that the facility follow up on computed tomography scanners that fail annual inspection by the medical physicist. **14.** We recommended that a medical physicist inspect computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), 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.		

Mammography Services

The purpose of this review was to determine whether the facility complied with selected VHA requirements regarding the provision of mammography services for women veterans.[g]

We reviewed relevant documents and the EHRs of 29 women veterans 50–74 years of age who had a screening mammogram July 1, 2014, to June 30, 2015, 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 policy addressing mammography services that included required elements.		
	If the facility outsourced mammograms, it defined requirements for turnaround time.		
X	Clinicians linked mammogram results to the radiology order in the EHR.	• Clinicians had not linked mammogram results to the radiology order in any of the 29 EHRs.	**15.** We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.
	Mammogram result reports included required elements.		
	Interpreting clinicians reported mammogram results using American College of Radiology codes.		
	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.		
NA	Clinicians communicated “suspicious” or “highly suggestive of malignancy” results and recommended actions to the patient within 5 business days of the procedure and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Clinicians communicated incomplete or "probably benign" results to the patient within 14 days from availability of the results and documented this in the EHR.		
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
NA	The facility ensured communication of "suspicious" or "highly suggestive of malignancy" results and the recommended course of action to the ordering clinician or responsible designee within 3 business days of the procedure date.		
	The facility designated a full-time Women Veterans Program Manager who was a health care professional with a minimal allotment of clinical time to maintain clinical competency.		
	The facility had established effective mammography oversight processes.		
	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.[h]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 20 new 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 full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
X	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees	• Ten of the 11 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**16.** We recommended that the facility ensure new clinical employees complete suicide risk management training within 90 days of being hired and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
NA	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.	• Clinicians had placed flags in the EHRs of three of four moderate- and low-risk patients.	**17.** We recommended that clinicians not place flags in the electronic health records of moderate- and low-risk patients and that facility managers monitor compliance.
X	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe	• Six of 33 safety plans (18 percent) lacked documentation of an assessment of available lethal means and how to keep the environment safe.	**18.** We recommended that clinicians include an assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags		
	The facility complied with any additional elements required by VHA or local policy.		

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of workplace violence.[i]

We reviewed relevant documents, three Reports of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period November 2014–October 2015, and 15 training records of employees who worked in areas at low, moderate, or high risk for violence. Additionally, we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

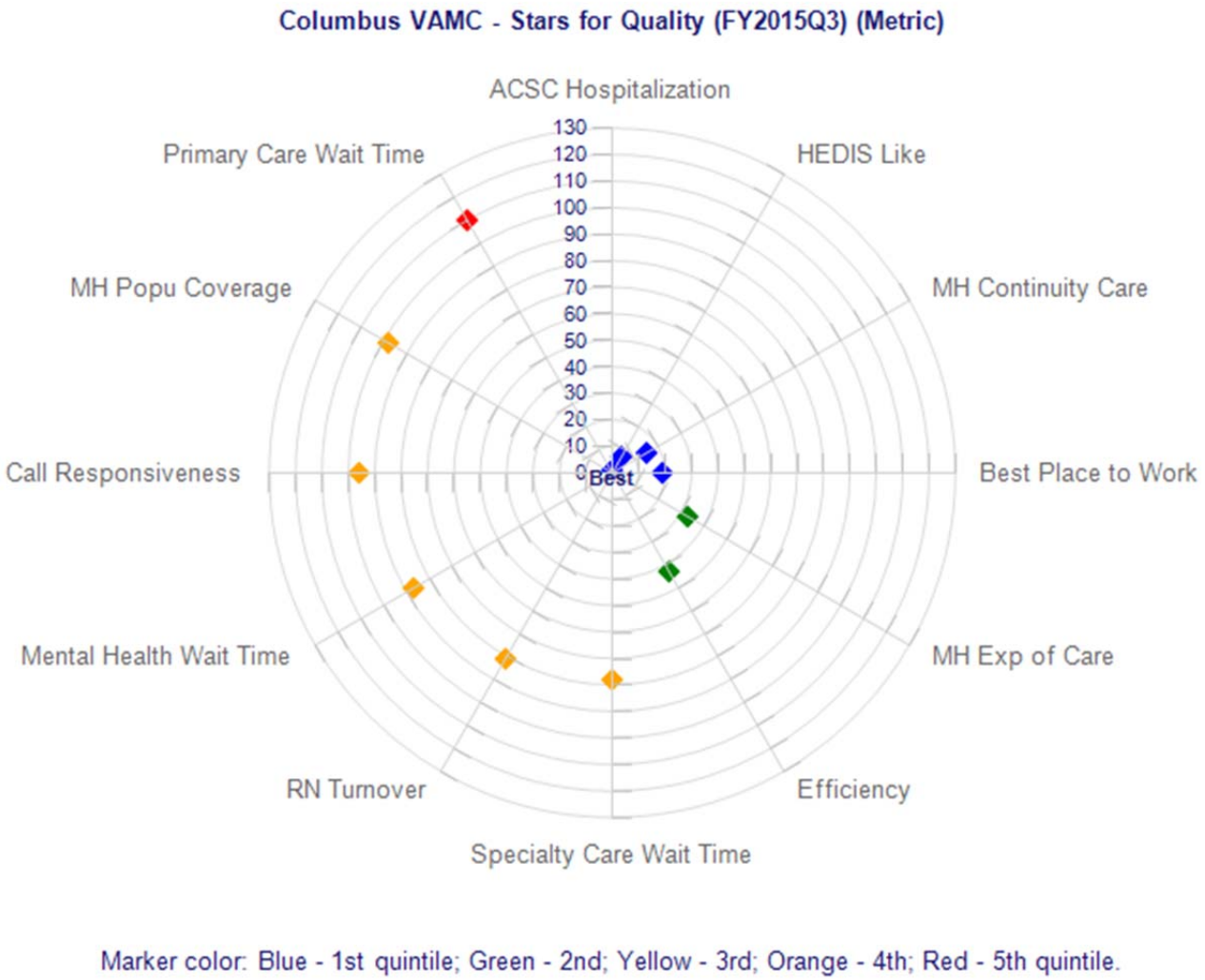
NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing workplace violence.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team • A Disruptive Behavior Committee/Board • A disruptive behavior reporting and tracking system		
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.		
	The facility had an employee security training plan that either used the mandated prevention and management of disruptive behavior training or an alternative that addressed the issues of awareness, preparedness, precautions, and police assistance. • Employees received the required training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility managed selected incidents appropriately according to its policy.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Columbus/757) FY 2016 through November 2015[1]	
Type of Organization	Secondary
Complexity Level	2 – Intermediate
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$209.6
Number (as of December 3, 2015) of:	
• **Unique Patients**	40,703
• **Outpatient Visits**	83,840
• **Unique Employees**[2]	1,194
Type and Number of Operating Beds (through October 2015):	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	NA
Average Daily Census:	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Zanesville/757GA Grove City/757GB Marion/757GC Newark/757GD
VISN Number	10

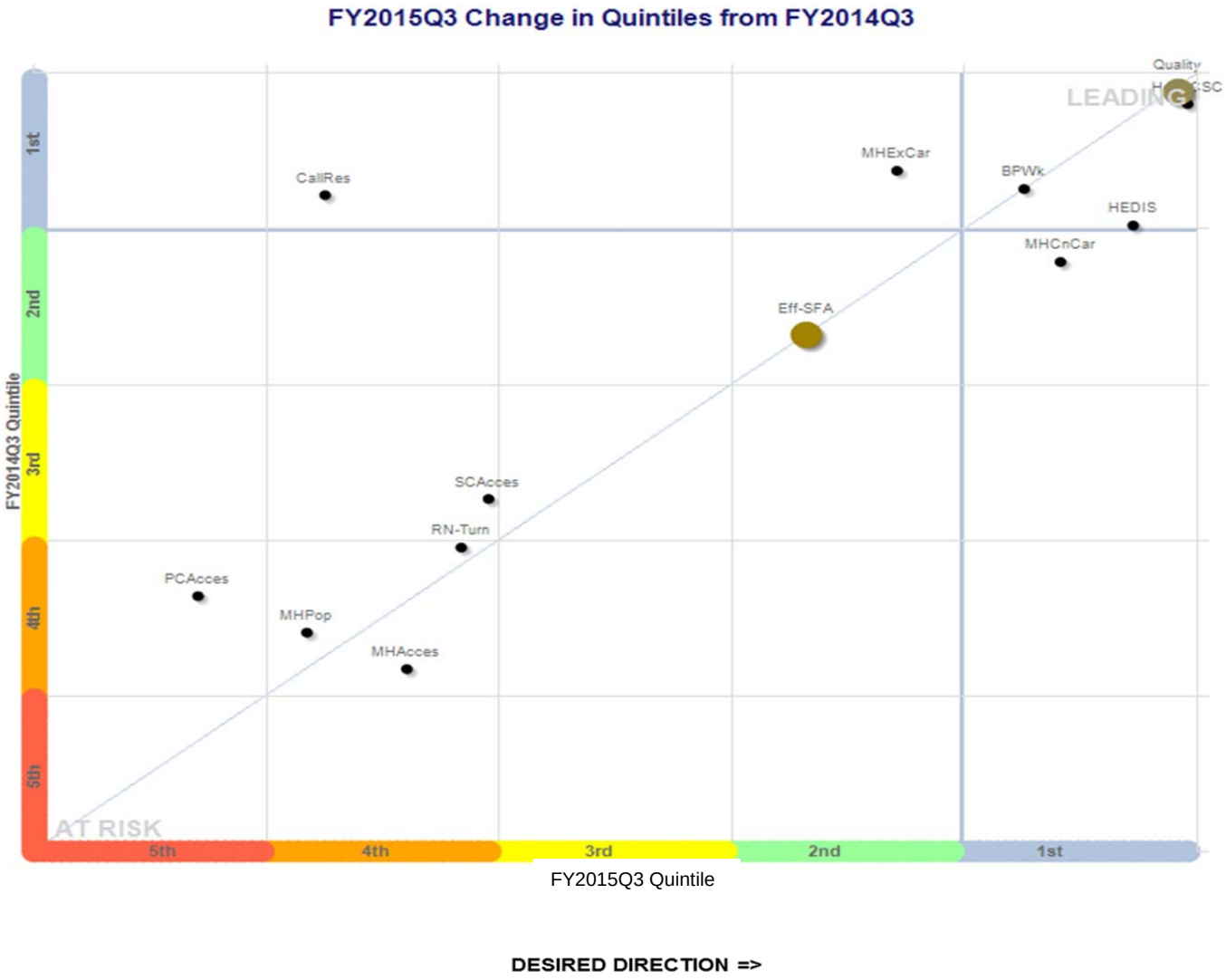
[1] All data is for FY 2016 through November 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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: December 11, 2015

From: Director, VA Healthcare System (10N10)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

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

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

1. I have reviewed and concur with the action plan regarding the Combined Assessment Program (CAP) review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH

2. The facility will ensure that the corrective action plan is implemented.

3. If you have any questions please contact Vicki Montague, VISN 10 QMO, at (216) 791-2300, ext. 5305.

J. Jane Johnson
for

Jack Hetrick
Network Director, VISN 10

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 11, 2015

From: Director, Chalmers P. Wylie VA Ambulatory Care Center (757/00)

Subject: **CAP Review of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH**

To: Director, VA Healthcare System (10N10)

1. Attached please find my comments and implementation plans in response to the recommendations identified in the OIG CAP Review conducted November 2–5, 2015, of the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH. I concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to Veterans.

3. Should you have questions or require further information, please contact me at (614) 257-5450

Keith Sullivan, FACHE
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 facility implement a consistent Ongoing Professional Practice Evaluation process.

Concur

Target date for completion: 08/01/2016

Facility response:

1. Medical Staff By-Laws and Credentialing and Privileging policies and procedures will clearly define the time period for completion, review, and reporting of completed OPPEs.

2. Each department will revise their OPPE tools to include department specific objective data that allows for the evaluation of quality care by the service chief.

3. A structure will be established for the reporting of OPPEs to Credentialing and Privileging that will allow for individual practitioner data to be presented.

4. Monitoring of the completion and reporting of OPPEs according to policy will occur monthly with a goal of 90% until compliance sustained. This data is to be reported to the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 2. We recommended that facility managers ensure patient care areas are clean and monitor compliance.

Concur

Target date for completion: 04/01/2016

Facility response:

1. Identified rooms were cleaned immediately.

2. Instituted monthly facility rounds by Associate Director and EMS Chief. Findings will be documented and tracked to completion.

3. Compliance will be monitored on weekly EOC rounds and results reported to the Environment of Care Committee and the Continuous Readiness Committee, with a

communication flow through the governance structure to the Executive Leadership Board.

4. Hire an additional EMS Supervisor.

5. Hire a full-time Trainer/Quality Control Inspector.

Recommendation 3. We recommended that the facility repair damaged furniture in patient care areas or remove it from service and repair damaged walls.

Concur

Target date for completion: 01/15/2016

Facility response:

1. Damaged chair was immediately removed in the identified group room.

2. Damaged lab exam chair was repaired on 11/18/15.

3. Wall repairs will be completed by 12/31/15.

4. Completion of actions will be documented and reported at the Environment of Care Committee and the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 4. We recommended that the facility repair or replace damaged vinyl floor tiles and heavily soiled, torn, and frayed carpeting in patient care areas.

Concur

Target date for completion: 06/01/2016

Facility response:

1. Damaged floor vinyl will be repaired by 3/16/16.

2. Frayed carpet will be replaced with vinyl by 5/27/16.

3. Completion of actions will be documented and reported at the Environment of Care Committee and the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 5. We recommended that facility managers ensure wheelchairs used by patients and visitors are clean and monitor compliance.

Concur

Target date for completion: 05/01/2016

Facility response:

1. Clarify and communicate the protocol for cleaning wheelchairs.

2. Wheelchairs cleanliness will be assessed during weekly EOC rounds.

3. Completion of actions from EOC rounds will be documented and reported at the Environment of Care Committee and the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 6. We recommended that facility policy include the frequency of competency assessment requirements for employees who prepare compounded sterile products.

Concur

Target date for completion: 03/16/2016

Facility response: Pharmacy Service will develop a new comprehensive Compounding Sterile Products policy based on requirements as stated in USP 797 which will define the frequency of competency assessments for all employees involved in sterile compounding. This policy will be communicated to all relevant Pharmacy staff. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 7. We recommended that pharmacy managers establish compounded sterile products competency assessment requirements for pharmacists.

Concur

Target date for completion: 03/16/2016

Facility response: Pharmacy Service will develop a new comprehensive Compounding Sterile Products policy based on requirements as stated in USP 797 which will define the competency assessments for pharmacists, as well as, all pharmacy technicians involved in sterile compounding. This policy will be communicated to all relevant Pharmacy staff. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 8. We recommended that pharmacy managers ensure pharmacy employees who prepare compounded sterile products complete all competency components annually and monitor compliance.

Concur

Target date for completion: 03/31/2016

Facility response: Pharmacy Service will develop a new comprehensive Compounding Sterile Products policy based on requirements as stated in USP 797 which will define the annual components of competency assessments for all employees involved in sterile compounding, as well as the process for pharmacy managers to monitor compliance. A compliance rate of 90% for all necessary competency assessments will be evaluated by the 03/31/2016 target date. The data will be reported to the Pharmacy and Therapeutics Committee, the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 9. We recommended that the facility revise the compounded sterile products safety/competency assessment checklist to include all required elements.

Concur

Target date for completion: 03/31/2016

Facility response: Pharmacy Service will develop a new comprehensive Compounding Sterile Products policy based on requirements as stated in USP 797 which will define the required actions for the compounded sterile products safety/competency assessment checklist. This will be communicated to all relevant Pharmacy staff. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 10. We recommended that pharmacy managers ensure employees who prepare compounded sterile products don all required personal protective equipment in the ante area prior to entering the IV Prep Room and monitor compliance.

Concur

Target date for completion: 01/31/2016

Facility response: Pharmacy Service will implement protocols for employees involved with compounding sterile products to don personal protective equipment in the Ante area prior to entering the IV Prep Room. This will be communicated to all Pharmacy staff and other employees, as relevant. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 11. We recommended that pharmacy managers ensure the IV Prep Room has sterile chemotherapy-type gloves available for compounding hazardous medications and monitor compliance.

Concur

Target date for completion: 01/31/2016

Facility response: Pharmacy Service will implement a protocol and monitoring guidelines for employees involved with compounding sterile products to don sterile chemotherapy-type gloves during compounding of hazardous medications. This will be communicated to all Pharmacy staff and other employees, as relevant. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 12. We recommended that facility managers ensure employees perform and document daily floor cleaning in the compounding area and monitor compliance.

Concur

Target date for completion: 12/31/2015

Facility response: Environmental Management Services (EMS) will develop a new comprehensive standard operating procedure (SOP) and competency for cleaning and disinfecting the compounding area based on requirements as stated in USP 797. All EMS staff designated to clean the IV Prep Room and Ante area will be trained on the new SOP. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 13. We recommended that the facility follow up on computed tomography scanners that fail annual inspection by the medical physicist.

Concur

Target date for completion: 02/28/2016

Facility response: Healthcare Technology Management (HTM) will develop a standard operating procedure to include a comprehensive scope of activities required of the medical physicist and the actions/documentation to be completed when any section of the annual inspection receives a failure rating. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 14. We recommended that a medical physicist inspect computed tomography scanners that had repairs or modifications that affected dose or image quality before return to clinical service and document the inspection and that facility managers monitor compliance.

Concur

Target date for completion: 03/31/2016

Facility response:

1. Healthcare Technology Management (HTM) will develop a standard operating procedure to include a comprehensive scope of activities required of the medical physicist and the actions/documentation to be completed when any section of the annual inspection receives a failure rating by 02/28/2016.

2. The current Medical Management Plan will be revised to clarify the roles and responsibility of HTM staff for decisions applicable to medical equipment use within the facility by 03/31/2016.

Completion of actions will be documented and reported at the Environment of Care Committee and the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 15. We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: 06/30/2016

Facility response:

1. Mammography Services in collaboration with Radiology and HIMs will establish a new standard operating procedure (SOP) that describes the process for linking mammogram results to the radiology order by 01/31/2016.

2. Identify staff responsible for implementation of the new SOP and provide education by 02/28/2016.

3. Established process will be monitored with a goal of 90% compliance by 6/30/16. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 16. We recommended that the facility ensure new clinical employees complete suicide risk management training within 90 days of being hired and that facility managers monitor compliance.

Concur

Target date for completion: 04/01/2016

Facility response:

1. The Suicide Risk Management training education within TMS will be assigned to all clinical new hires.

2. Monitoring of the completion of the TMS suicide risk management education by new clinical hires will occur monthly with a target goal of 90% until compliance maintained. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 17. We recommended that clinicians not place flags in the electronic health records of moderate- and low-risk patients and that facility managers monitor compliance.

Concur

Target date for completion: 05/01/2016

Facility response:

1. Education will be provided to the Behavioral Health staff regarding the appropriate placement of the Risk for Suicide PRF.

2. The Risk for Suicide PRF will be monitored for compliance with a goal of 90% until compliance sustained. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Recommendation 18. We recommended that clinicians include an assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: 05/01/2016

Facility response:

1. Education will be provided to the Behavioral Health staff regarding the completion of the assessment of lethal means and documentation in the Suicide Prevention Safety Plan.

2. Suicide Prevention Safety Plans will be monitored for completion of the lethal means assessment with a goal of 90% until compliance sustained. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- 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, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

[e] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

[f] 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.

[g] References used for this topic included:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

[h] References used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected February 3, 2011).
- 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.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[i] References used for this topic were:

- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.