Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05497-132

Combined Assessment Program Review of the VA Maryland Health Care System Baltimore, Maryland

February 23, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	VA Maryland Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

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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 December 7, 2015.

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

- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were opening a Radiation Oncology Department and improving care for homeless veterans.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Review Ongoing Professional Practice Evaluation data biannually. Require Physician Utilization Management Advisors to document decisions in the National Utilization Management Integration database. Ensure the Patient Safety Manager enters all reported patient incidents into the WEBSPOT database.

Environment of Care: Ensure Environment of Care Committee meeting minutes reflect sufficient discussion of environment of care rounds deficiencies, corrective actions taken, and tracking of actions to closure. Require that Infection Control Committee meeting minutes consistently reflect discussion of hand hygiene data, actions implemented, and follow-up on actions. Ensure all health care occupancy buildings at the Baltimore and Loch Raven campuses have at least one fire drill per shift per quarter and documented drill critiques. Require that mental health unit and public restrooms at the Baltimore campus are clean. Ensure functionality of negative pressure systems at the Baltimore and Perry Point campuses. Promptly remove expired medications from patient care areas. Require that the Baltimore campus Emergency Department's main entrance door is functional. Ensure all Baltimore campus dental clinic employees complete mandatory training. Require that operating room housekeepers complete training on cleaning and disinfection procedures. Consistently monitor operating room temperature and humidity.

Medication Management: Complete and document periodic surface sampling in the inpatient pharmacy area. Ensure functionality of the airflow monitoring system alarms in the compounded sterile product ante area. Require the inpatient pharmacy to have sterile chemotherapy-type gloves available. Perform and document routine cleaning of laminar flow hoods, counters, floors, and storage shelving in the compounding area.

Coordination of Care: Ensure that physicians document transfer notes and that attending physicians document a separate admission note or addendum within 1 day of the patient's admission.

Advance Directives: Scan the most current advance directive into the electronic health record. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe. Include in Suicide Prevention Safety Plans the identification of contact numbers of family or friends for support, and ensure patients and/or family members receive a copy of the plan.

Comments

The Acting 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 25–36, 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 seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- 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 2015 and FY 2016 through December 11, 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 VA Maryland Health Care System, Baltimore, Maryland,* Report No. 13-00896-234, July 11, 2013).

During this review, we presented crime awareness briefings for 61 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 312 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

Radiation Oncology Department

The Radiation Oncology Department opened on December 15, 2014. Veterans previously received radiation treatments at a non-VA facility. The department currently treats 25 patients a day, and approximately 350 veterans have received treatment within the past year. A radiation oncologist sees all veterans within 3 to 5 days of the initial consult and within the same day for emergencies. The department received excellent results from the three surveys conducted during the past year by The Joint Commission, the National Health Physics Program, and an independent group from the MD Anderson Cancer Center. The patient satisfaction rating average is five out of five. The Radiology Oncology Department is a true example of patient- and family-centered care.

Improved Care for Homeless Veterans through Community Resources

The facility collaborated with the Mayor of Baltimore and other community resources to implement several initiatives to end veteran homelessness. Actions taken include a public awareness campaign, partnerships with local businesses/agencies to increase available housing, and arrangements with the University of Maryland School of Dentistry to treat eligible homeless veterans. Additionally, a Maryland District Judge created a veterans docket to assist veterans who have medical and behavioral health needs.

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, 18 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, 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 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' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation 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.	• None of the 18 profiles contained evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data biannually.	**1.** We recommended that facility clinical managers review Ongoing Professional Practice Evaluation data biannually and that facility managers monitor compliance.

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.		
X	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.	• For 1,395 of the 1,517 cases (92 percent) referred to Physician Utilization Management Advisors October 1–December 2, 2015, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**2.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
X	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.	• The Patient Safety Manager did not enter 400 patient incidents reported in FY 2015 into the WEBSPOT database.	**3.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

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 and the OR.[b]

At the Baltimore campus, we inspected the surgical, medical, post-anesthesia care, and locked MH units; the medical and surgical intensive care units; the Emergency Department; the Psychosocial Residential Rehabilitation Treatment Program; the OR; and the dental clinic. At the Perry Point campus, we inspected the medical, chronic ventilator, and locked MH units; urgent care; two community living center units; the Women's Health Program; and the dental clinic. At the Loch Raven campus, we inspected two community living center units and the Physical Therapy and Rehabilitation Program area. Additionally, we reviewed relevant documents and 39 employee training records (19 OR housekeeper and 20 dental clinic—10 each from the Baltimore and Perry Point campuses), and we 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
X	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.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect sufficient discussion of EOC rounds deficiencies, corrective actions taken, and tracking of actions to closure for the three campuses and for the community based outpatient clinics.	**4.** We recommended that Environment of Care Committee meeting minutes reflect sufficient discussion of environment of care rounds deficiencies, corrective actions taken to address the deficiencies, and tracking of actions to closure for the three campuses and for the community based outpatient clinics.
	The facility conducted an infection prevention risk assessment.		
X	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.	Eight months of Acute Care and 5 months of Non-Acute Care Infection Control Committee meeting minutes reviewed: • Minutes did not consistently reflect discussion of hand hygiene data identified as a high-risk priority area, actions implemented, and follow-up on actions implemented for all three campuses.	**5.** We recommended that Acute Care and Non-Acute Care Infection Control Committee meeting minutes consistently reflect discussion of hand hygiene data, actions implemented, and follow-up on actions implemented for the three campuses.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had established a process for cleaning equipment between patients.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Past 2 quarters of fire drill documentation for health care occupancy buildings reviewed: • The Baltimore and Loch Raven campuses did not consistently conduct fire drills once per shift per quarter in each building designated for health care occupancy and did not consistently have documented drill critiques.	**6.** We recommended that facility managers ensure all health care occupancy buildings at the Baltimore and Loch Raven campuses have at least one fire drill per shift per quarter and have documented fire drill critiques and monitor compliance.
	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.		
X	The facility met environmental safety requirements.	• At the Baltimore campus, locked MH unit bathrooms and public bathrooms on the 3rd, 5th, and 6th floors were in need of more frequent and comprehensive cleaning.	**7.** We recommended that facility managers ensure the locked mental health unit and public bathrooms on the 3rd, 5th, and 6th floors at the Baltimore campus are frequently and thoroughly cleaned and monitor compliance.
X	The facility met infection prevention requirements.	• At the Baltimore campus, none of the 12 negative air pressure systems in isolation rooms were functional, and at the Perry Point campus, neither of the 2 systems inspected were functional.	**8.** We recommended that facility managers ensure functionality of negative air pressure systems in all designated rooms at the Baltimore and Perry Point campuses and monitor compliance.
X	The facility met medication safety and security requirements.	• The Baltimore locked MH unit, Perry Point chronic ventilator unit and community living center 23-B unit, and Lock Raven community living center-2 unit had expired medications.	**9.** We recommended that employees at all three campuses promptly remove expired medications from patient care areas and that facility managers monitor compliance.
	The facility met privacy requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	The Joint Commission requires that hospitals manage safety and security risks. • At the Baltimore campus, the Emergency Department main entrance door was broken, posing a risk for outsiders to easily access the hospital.	**10.** We recommended that facility managers ensure the Baltimore campus Emergency Department main entrance door is functional and monitor compliance.
	Areas Reviewed for Dental Clinic		
X	Dental clinic employees completed bloodborne pathogens training within the past 12 months.	• At the Baltimore campus, 3 of 10 dental clinic employees did not have documentation of bloodborne pathogens training during the past 12 months.	**11.** We recommended that dental clinic managers ensure all Baltimore campus dental clinic employees complete bloodborne pathogens training annually and monitor compliance.
X	Dental clinic employees received hazard communication training on chemical classification, labeling, and Safety Data Sheets.	• At the Baltimore campus, 3 of 10 dental clinic employees did not have documentation of hazard communication training on chemical classification, labeling, and Safety Data Sheets.	**12.** We recommended that dental clinic managers ensure all Baltimore campus dental clinic employees complete hazard communication training on chemical classification, labeling, and Safety Data Sheets and monitor compliance.
X	Designated dental clinic employees received laser safety training in accordance with local policy.	• At the Baltimore campus, 3 of 10 designated dental clinic employees did not have documentation of laser safety training.	**13.** We recommended that dental clinic managers ensure designated Baltimore campus dental clinic employees complete laser safety training and monitor compliance.
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		
	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
	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.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
X	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.	• Six of 19 housekeepers assigned to the OR did not receive training on cleaning and disinfection procedures.	**14.** We recommended that facility managers ensure operating room housekeepers complete training on cleaning and disinfection procedures.
X	The facility monitored OR temperature, humidity, and positive pressure.	• Facility employees did not consistently monitor temperature and humidity in the OR.	**15.** We recommended that facility managers ensure consistent monitoring of operating room temperature and humidity and monitor compliance.
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

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 11 pharmacy employees (6 pharmacists and 5 technicians). Additionally, we inspected one 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		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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 controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
X	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.	• There was no evidence of periodic surface sampling in the inpatient pharmacy area.	**16.** We recommended that facility managers ensure completion and documentation of periodic surface sampling in the inpatient pharmacy area and monitor compliance.
	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.	• The CSP ante area airflow monitoring system alarms were not functional.	**17.** We recommended that facility managers ensure the airflow monitoring system alarms in the compounded sterile product ante area are functional.
	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 inpatient pharmacy did not have sterile chemotherapy-type gloves available for compounding hazardous medications.	**18.** We recommended that facility managers ensure the inpatient pharmacy has sterile chemotherapy-type gloves available for compounding hazardous medications and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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 routine cleaning of the laminar flow hoods, counters, floors, and storage shelving in the compounding area.	**19.** We recommended that facility managers ensure employees perform and document routine cleaning of laminar flow hoods, counters, floors, and storage shelving 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.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. 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 that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
X	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.	• For 4 of the 30 applicable EHRs (13 percent), attending physicians did not document a separate admission note or addendum within 1 day of the patient's admission.	**20.** We recommended that attending physicians consistently document a separate admission note or addendum within 1 day of the patient's admission.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
X	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.	• For 2 of the 16 applicable EHRs, physicians did not document transfer notes.	**21.** We recommended that physicians document transfer notes and that facility managers monitor compliance.
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	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.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 12 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 49 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: • 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		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	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 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.		
NA	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 patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. 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 an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For 2 of the 14 applicable EHRs, employees had not scanned the most current AD into the EHR.	**22.** We recommended that employees consistently scan the most current advance directive into the electronic health record and that facility managers monitor compliance.
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Fifteen of the 34 EHRs did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**23.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met 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.[g]

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 26 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.

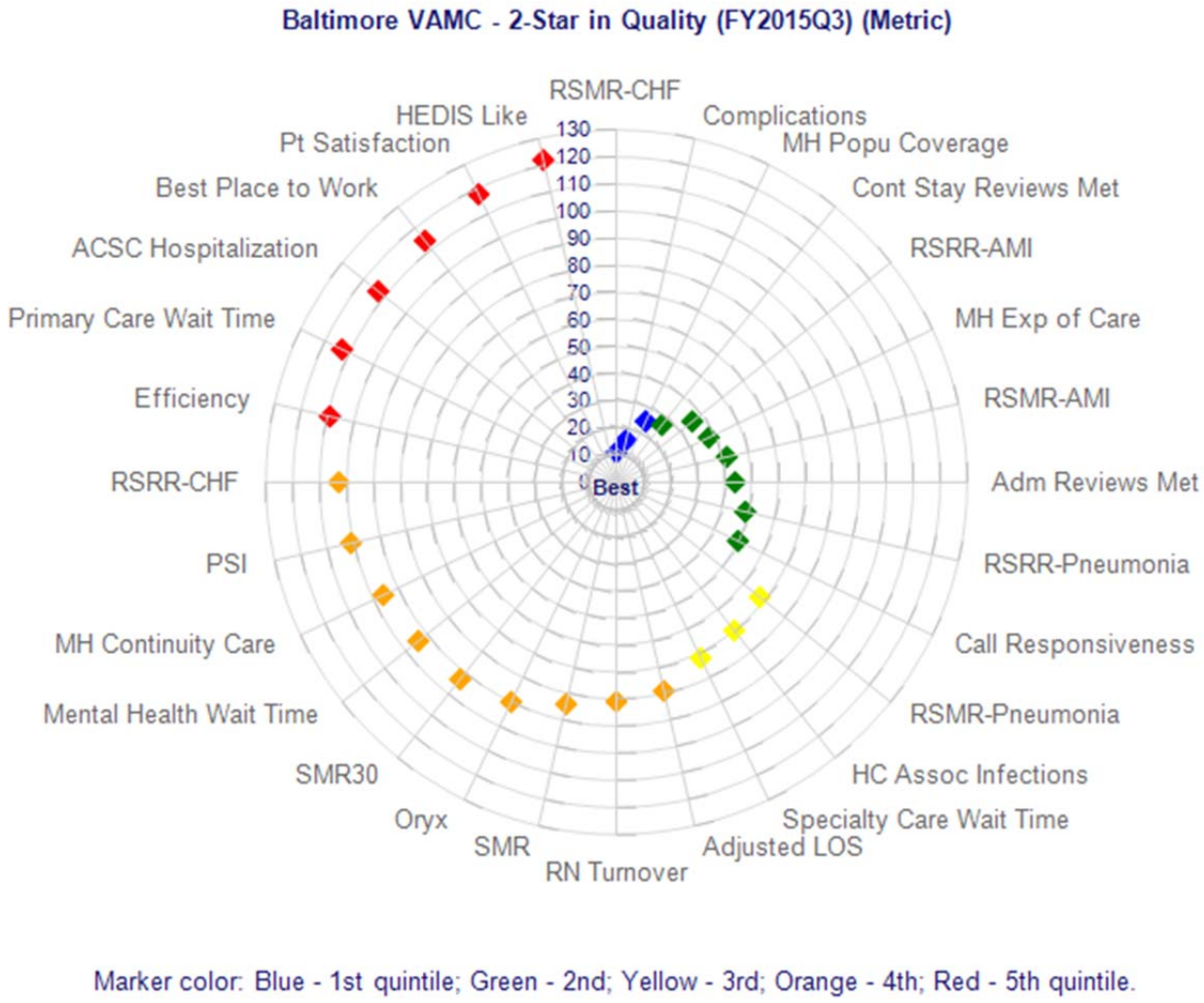
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk 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	• None of the 15 applicable training records indicated that clinicians completed suicide risk management training within 90 days of being hired.	**24.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe 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.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
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 38 safety plans (16 percent) lacked documentation of the identification of contact numbers of family or friends for support.	**25.** We recommended that clinicians include the identification of contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In 4 of 38 EHRs (11 percent), clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**26.** We recommended that clinicians ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
	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.		

Facility Profile (Baltimore/512) FY 2016 through December 2016	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$116.8
Number of:	
• **Unique Patients**	33,095
• **Outpatient Visits**	129,275
• **Unique Employees**[1]	2,951
Type and Number of Operating Beds:	
• **Hospital**	236
• **Community Living Center**	263
• **MH**	145
Average Daily Census:	
• **Hospital**	84
• **Community Living Center**	152
• **MH**	67
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Cambridge/512GA Glen Burnie/512GC Baltimore/512GD Pocomoke City/512GE Fort Howard/512GF Fort Meade/512GG
Veterans Integrated Service Network Number	5

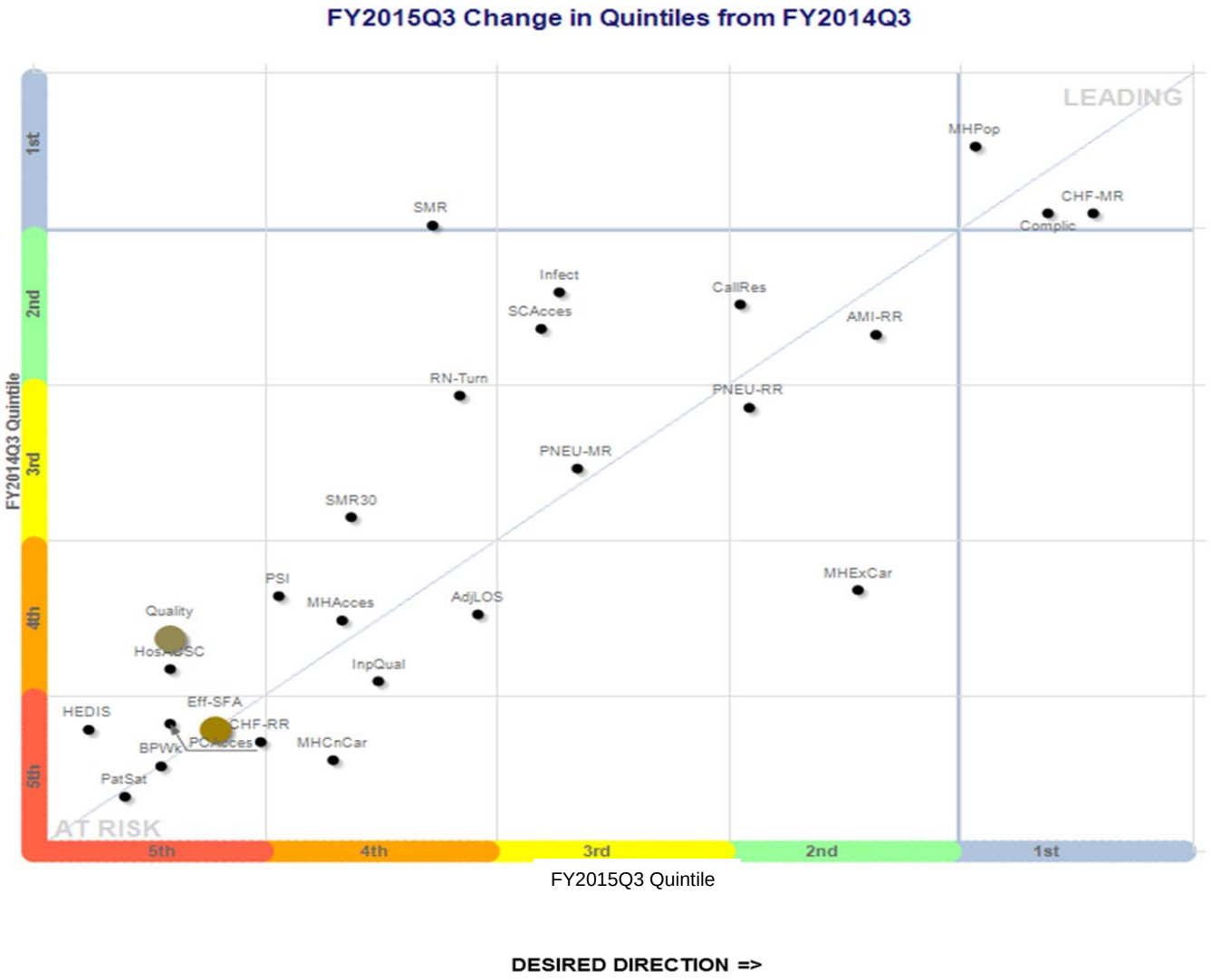
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] 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

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: February 9, 2016

From: Acting Director, VA Capitol Health Care Network (10N5)

Subject: **CAP Review of the VA Maryland Health Care System, Baltimore, MD**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed the comments provided by the Medical Center Director of the VA Maryland Health Care System, and concur with the responses and actions to the recommendations outlined in the report.

2. Should you require additional information, please contact Jeffrey Lee, Quality Management Officer, VA Capitol Health Care Network, VISN 5, at 954-541-7514.

FOR Joseph A. Williams, Jr.

Attachments: 4

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 29, 2016

From: Director, VA Maryland Health Care System (512/00)

Subject: **CAP Review of the VA Maryland Health Care System, Baltimore, MD**

To: Director, VA Capitol Health Care Network (10N5)

1. I would like to express my appreciation to the Office of Inspector General Survey Team for their professional and comprehensive review conducted on December 7–11, 2015.

2. I have reviewed the draft report for the VA Maryland Health Care System, Baltimore, Maryland, and concur with the findings and recommendations.

3. Please express my gratitude to the survey team for their professionalism and assistance to us in our continuing efforts to provide the best care possible to our Veteran patients.

Adam M. Robinson, Jr., M.D.
ADAM M. ROBINSON, JR., M.D.

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 clinical managers review Ongoing Professional Practice Evaluation data biannually and that facility managers monitor compliance.

Concur

Target date for completion: May 5, 2016

Facility response: The VA Maryland Healthcare System responds:

(A) Medical Service Office will create an agenda item for biweekly Professional Standards Board meetings in March and September of each Fiscal Year. This agenda item will remind Clinical Center Directors and Clinical Service/Department Chiefs of the semi-annual OPPE Counseling requirement. This reminder will also be included in the Professional Standards Board minutes for March and September of each FY. Suspense: March 3, 2016.

(B) Clinical Center Directors and Clinical Service/Department Chiefs will perform their required ePerformance counseling during the months of March and September. OPPE counseling will become a semi-annual requirement for ePerformance counseling. Directors and Chiefs will then report successful completion of OPPE counseling, and documentation of the same in ePerformance, during the April and October Professional Standards Board meetings of each FY. This requirement will be discussed during the next Executive Committee of the Medical Staff meeting in February 2016. Suspense: April 7, 2016.

(C) Clinical Center Directors and Clinical Service/Department Chiefs will be directed to populate their ePerformance counseling as follows: "OPPE Counseling was performed on _____ (date)." Suspense: February 28, 2016.

(D) The office of Quality, Safety and Improvement and the Medical Service Office will routinely check ePerformance Counseling for the presence or absence of OPPE Counseling, then review non-compliance during biweekly Professional Standards Boards meetings starting in May 2016. Suspense: May 5, 2016.

Recommendation 2. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: Physician Utilization Management Advisors (PUMA) have been identified for all Clinical Centers. PUMA education is in TMS and all PUMAS have been given access to the website to complete training. All PUMAS have been added to the National Utilization Management Integration Database (NUMI). Weekly compliance data will be pulled from NUMI to validate completion of reviews. The Medical Director, Patient Flow Center will follow up with the PUMAS who are non-compliant.

Recommendation 3. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

Concur

Target date for completion: April 25, 2016

Facility response: The incident reports for FY14 will be uploaded into the SPOT database by February 29, 2016. The incidents from Q1 FY16 (Oct 2015-Dec 2015) will be entered into the SPOT database by March 28, 2016. The incidents from Q2 FY16 (Jan 2016–March 2016) will be entered into SPOT database by April 25, 2016. Starting April 2016, each month's incident will be entered into the SPOT by the end of the following month i.e. April 2016 will be entered by the end of May 2016. Monthly reconciliation of the incidents in the EIR and in SPOT will be completed by the Patient Safety Manager for the reminder of the fiscal year to ensure ongoing compliance.

Recommendation 4. We recommended that Environment of Care Committee meeting minutes reflect sufficient discussion of environment of care rounds deficiencies, corrective actions taken to address the deficiencies, and tracking of actions to closure for the three campuses and for the community based outpatient clinics.

Concur

Target date for completion: September 30, 2016

Facility response: The previous monthly report will now be the quarterly report as advised by the surveyor. This report will encompass a full data report of all deficiencies to include length of time that the deficiency has been open, categories of deficiencies, and how many of those deficiencies have action plans in place. In addition, a monthly report has been implemented to track individual critical deficiencies from the prior month including areas where deficiencies were located and current status of each deficiency.

Critical items will be addressed and discussed in the monthly report to ensure that action plans for each deficiency are tracked to completion.

Recommendation 5. We recommended that Acute Care and Non-Acute Care Infection Control Committee meeting minutes consistently reflect discussion of hand hygiene data, actions implemented, and follow-up on actions implemented for the three campuses.

Concur

Target date for completion: September 1, 2016

Facility response: Short term: Consolidate the Hand Hygiene data to be inclusive of all services. By March 2016 all hand hygiene observations for FY16 Q1 and January 2016 will be provided to Patient Safety for Acute Care and CBOCs and Perry Point Infection Control for the Perry Point and Loch Raven campuses. The data in collaboration with Patient Safety/Infection Control will be presented to the Infection Control Manager/Hospital Epidemiologist prior to the infection control meetings for analysis and trending. Long Term: Create one Hand Hygiene database that would be accessed through the VA Maryland Health Care System webpage/portal. Trained observers would expand to include other disciplines as well as those performing clinical audits that will be given access to enter hand hygiene observations into this portal. The database will have the capability to be displayed by unit/location and by positions (e.g. resident, nutrition) for further trending and analysis purposes. Access to the Share Point would allow services the ability of accessing their own data/reports. This will require IT support/programming support for creation of Share Point/portal for data entry and ability to create charts and export reports. Estimated date of completion, end of FY16. The MDRO Infection Control Nurse under the direction of the Infection Control Program Manager will be responsible for the ownership, coordination and dissemination of the Hand Hygiene data. Hand Hygiene observations shall be collected monthly for acute care, long term care and CBOCs by trained secret observers. The MDRO Infection Control Nurse and Infection Control staff will be responsible for providing the training. The data shall be displayed in three month segments minimally for trending and analysis purposes.

Recommendation 6. We recommended that facility managers ensure all health care occupancy buildings at the Baltimore and Loch Raven campuses have at least one fire drill per shift per quarter and have documented fire drill critiques and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: To ensure compliance, monitoring of fire drill dates/times will be reported to the Environment of Care Committee on a quarterly basis, as part of the Life Safety Management plan report. This will commence at the next Environment of Care meeting on February 8, 2016. Self-evaluation forms have been issued through the AD

for Patient Care Services to the Nurse Managers. These forms will be used for fire drill critiques and submitted to the VAMHCS Safety Office to augment those completed by safety staff. This is currently in place and will be evaluated monthly, with anticipated closure by the end of the second quarter.

Recommendation 7. We recommended that facility managers ensure the locked mental health unit and public bathrooms on the 3rd, 5th, and 6th floors at the Baltimore campus are frequently and thoroughly cleaned and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: EMS leadership is in discussion with local labor partners to reinstitute a daily/hourly sign-in sheet to be used as a cleaning quality assurance validation tool in the medical center restrooms. This document will require employees to initial completed work as scheduled on an hourly basis.

Recommendation 8. We recommended that facility managers ensure functionality of negative air pressure systems in all designated rooms at the Baltimore and Perry Point campuses and monitor compliance.

Concur

Target date for completion: September 2016

Facility response: Leadership is currently reviewing the number and location of isolation rooms throughout the facility to decide how many isolations rooms are needed and where they will be located. Baltimore will update the ventilation system associated with the rooms that will remain designated for negative pressure. The isolation room that is located in the emergency department is functioning. This room has a dedicated exhaust fan. Neither the air exchanges nor differential pressure of this room are impacted by any other rooms. The visual and audible indication near the entrance of the room accurately provides the status of the room. The ventilation of the room is monitored and recorded by the energy management system. The other remaining negative pressure/respiratory isolation room, that is currently in use, is located on 3B, a telemetry unit. Adjustments have been made to the other negative pressure/respiratory isolation rooms on the unit, which are serviced by the same exhaust fan. These adjustments were done in an effort to isolate the rooms from the shared isolation exhaust fan. There are both visual and audible indications at the entrance to the negative pressure/respiratory room that provides the operational status of the room. The parameters are also recorded continuously by the energy management system.

Recommendation 9. We recommended that employees at all three campuses promptly remove expired medications from patient care areas and that facility manager's monitor compliance.

Concur

Target date for completion: May 1, 2016

Facility response: Pharmacy staff will be educated at the February staff meeting that any time an Omnicell is accessed, they must check for expired medications, to include routine re-stocking, during ward inspections, and any time they access the Omnicell. This education will be reiterated at the March and April staff meetings. Monthly spot inspections will be performed once ward stocks are completed for three months.

Recommendation 10. We recommended that facility managers ensure the Baltimore campus Emergency Department main entrance door is functional and monitor compliance.

Concur

Target date for completion: June 1, 2016

Facility response: The doors will be restored to full service upon completion of the renovation project. As of the date of this report, the doors to the main entrance of the emergency department are completely blocked from patient/staff use and construction is underway.

Recommendation 11. We recommended that dental clinic managers ensure all Baltimore campus dental clinic employees complete blood borne pathogens training annually and monitor compliance.

Concur

Target date for completion: February 22, 2016

Facility response: The Dental Director (supervisor) will ensure that all Baltimore campus dental clinic employees complete required blood borne pathogens training annually and monitor compliance. Timely completion of employee education requirements is a performance standard for all dental staff.

Recommendation 12. We recommended that dental clinic managers ensure all Baltimore campus dental clinic employees complete hazard communication training on chemical classification, labeling, and Safety Data Sheets and monitor compliance.

Concur

Target date for completion: February 22, 2016

Facility response: The Dental Director (supervisor) will ensure that all Baltimore campus dental clinic employees complete required hazard communication training (chemical classification, labeling, and Safety Data Sheets) annually and monitor compliance. Timely completion of employee education requirements is a performance standard for all dental staff.

Recommendation 13. We recommended that dental clinic managers ensure designated Baltimore campus dental clinic employees complete laser safety training and monitor compliance.

Concur

Target date for completion: February 22, 2016

Facility response: Required TMS training "Laser Safety Training, NFED 38070739" was added to the learning plans of dental providers and support personnel utilizing or assisting with dental procedures involving lasers. Annual training is required following completion of initial laser safety training. Timely completion of employee education requirements is a performance standard for all dental staff. A TMS Assignment Profile (AP) has been created to assign the training item "Laser Safety Training, NFED 38070739" to the learning plans of Baltimore Dental Assistants. Assignment to dentists will be made on a case-by-case basis since only select qualified dentists may perform laser procedures. The purpose of the AP is to ensure that all employees required to complete the training will have the item assigned to their TMS account. The employee will have 30 days to complete the training. Compliance will be monitored by the employee's supervisor to ensure completion of training.

Recommendation 14. We recommended that facility managers ensure operating room housekeepers complete training on cleaning and disinfection procedures.

Concur

Target date for completion: June 1, 2016

Facility response: OR training has been instituted for all OR staff to include supervisors who cross-train into the OR area. Any new employees who are assigned to the OR will receive the enhanced training to include all supervisors assigned to the OR. To ensure compliance, departmental leadership will monitor to ensure that employee training is completed and documented.

Recommendation 15. We recommended that facility managers ensure consistent monitoring of operating room temperature and humidity and monitor compliance.

Concur

Target date for completion: June 1, 2016

Facility response: Consistent monitoring is occurring at this time. Facilities & Engineering staff will continue to work with OR leadership to replace/repair any temperature and relative humidity devices that are not operating properly, as needed.

Recommendation 16. We recommended that facility managers ensure completion and documentation of periodic surface sampling in the inpatient pharmacy area and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: Surface sampling will begin in January 2016 and will continue according to USP 797 guidelines. Compliance will be monitored on a monthly basis for at least three months.

Recommendation 17. We recommended that facility managers ensure the airflow monitoring system alarms in the compounded sterile product ante area are functional.

Concur

Target date for completion: March 1, 2016

Facility response: The hoods will be certified, after which a licensed professional will perform an air balance with any necessary ventilation changes. After the air balance is performed, alarms will be restored to service.

Recommendation 18. We recommended that facility managers ensure the inpatient pharmacy has sterile chemotherapy-type gloves available for compounding hazardous medications and monitor compliance.

Concur

Target date for completion: February 4, 2016

Facility response: Pharmacy currently working to purchase the appropriate gloves with expected arrival date of February 2, 2016. Staff will be instructed to double-glove with sterile gloves on the outside. The Inpatient Pharmacy Supervisor will spot-check employees for compliance a minimum of once per week beginning with the date of implementation.

Recommendation 19. We recommended that facility managers ensure employees perform and document routine cleaning of laminar flow hoods, counters, floors, and storage shelving in the compounding area and monitor compliance.

Concur

Target date for completion: April 1, 2016

Facility response: Documentation is now occurring per protocol. The documentation sheets are currently on the laminar flow hoods and will be checked monthly to ensure ongoing compliance.

Recommendation 20. We recommended that attending physicians consistently document a separate admission note or addendum within 1 day of the patient's admission.

Concur

Target date for completion: July 1, 2016

Facility response: Surgery admissions occur via two mechanisms: A) direct through OR and B) admitting/ER. For the former we have initiated a process that guarantees 100 percent compliance, in that admission to the OR requires attending co-signature on the passport form that contains the attending admission note. This form will need to be approved through the forms committee. For other admissions we will work through Surgical PI to monitor all floor admissions weekly and assess for necessary documentation. Surgical PI already assesses for patients from group (A).

Recommendation 21. We recommended that physicians document transfer notes and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: Surgical PI is monitoring the presence of transfer notes, and has just introduced a Hard Stop (no patient is transferred by MSA's or nursing unless that note is present).

Recommendation 22. We recommended that employees consistently scan the most current advance directive into the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: May 2016

Facility response: Social Work is working with MAS to research potential gaps in the scanning process. If identified, improvements will be made to ensure that the advanced directives are sent to Medical Administrative Service and scanned in a timely manner. Compliance monitoring will be completed by social work. Scanned copies are filed in the MAS file room in a red folder. The supervisor reviews all scanned copies of the AD.

Recommendation 23. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: Nursing Service has updated the questions in the VA nursing assessment to better reflect the need for screening for advance directives upon admission, and for referring to Social Work to have the advance directives completed. Nursing and Social Work staff have been educated regarding the changes and the importance of documenting advance directives. Nursing Supervisors will review 25 charts per month for the next two months to ensure that patients are being asked if they would like to create, change or revoke advance directives. Social Work supervisors will also review the same 25 charts to ensure that the appropriate advance directive note titles are being used.

Recommendation 24. We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.

Concur

Target date for completion: February 22, 2016

Facility response: TMS Assignment Profile (AP) has been created to assign the training item Suicide Risk Management Training for Clinicians to the learning plans of the following job positions: *Physician, Psychologist, Registered Nurse, Social Worker, Physician Assistant, Pharmacist, and Dentist.* On November 20, 2015, training was added to TMS accounts for all employees hired between 2008 and November 19, 2015, as it was identified that the training had been removed. This is now required training for the disciplines listed above. To ensure compliance, departmental leadership will monitor for 3 months with routine monitoring thereafter.

Recommendation 25. We recommended that clinicians include the identification of contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: May 23, 2016

Facility response: The Suicide Prevention Team will provide in-services on both inpatient psychiatry units to educate as to the need to fill in this section of the Suicide Prevention Safety Plan. To ensure compliance, departmental leadership will monitor for 3 months with routine monitoring thereafter.

Recommendation 26. We recommended that clinicians ensure patients and/or family members receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: May 23, 2016

Facility response: The Suicide Prevention Team will provide in-services on both inpatient psychiatry units to educate as to the requirement to document that they gave the patients and/or caregivers the plan. A radio button has been included in the template, as a reminder of both giving the plan and documenting the plan has been given. To ensure compliance, departmental leadership will monitor for 3 months with routine monitoring thereafter.

Office of Inspector General
Contact and Staff Acknowledgments

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

Endnotes

[a] References used for this topic 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. Pharmacopeia 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 Pharmacopeia 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] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[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 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- 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.