Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00106-211

Combined Assessment Program Review of the Charlie Norwood VA Medical Center Augusta, Georgia

March 28, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Charlie Norwood VA Medical Center
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
SAIL	Strategic Analytics for Improvement and Learning
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 25, 2016.

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

- Coordination of Care
- Advance Directives

The facility's reported accomplishments were improvements in Strategic Analytics for Improvement and Learning (SAIL) data and improved efficiency across the facility.

Recommendations: We made recommendations in the following five activities:

Quality, Safety, and Value: Require Physician Utilization Management Advisors to consistently document their decisions in the National Utilization Management Integration database. Ensure the Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOT database.

Environment of Care: Ensure personal protective equipment masks are available in all patient care areas. Secure medication carts when not in use, remove expired medications from patient care areas, and date multi-dose vials when opened.

Medication Management: Ensure the inpatient pharmacy has sterile chemotherapy-type gloves available for compounding hazardous medications.

Computed Tomography Radiation Monitoring: Ensure a medical physicist completes and documents inspections of computed tomography scanners following repair or modifications affecting dose or image quality.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe. Consistently provide at least five community outreach activities every month. Develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk. Follow up with high-risk patients at least four times during the first 30 days after discharge.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–29, for the full text of the Directors' comments.) We consider recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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

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

Scope

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

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following 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 January 25, 2016, 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 Charlie Norwood VA Medical Center, Augusta, Georgia,* Report No. 13-01972-284, August 19, 2013).

During this review, we presented crime awareness briefings for 463 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 333 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

Recognition for SAIL Metrics Improvement

The facility was recognized by Deputy Secretary of Veterans Affairs Sloan D. Gibson for having one of the best improvements in its SAIL performance in FY 2015. Specific accomplishments included the following:

- The facility had the 5th greatest improvement in 18 of 26 SAIL metrics among VA medical facilities and improved from a 1-Star to a 2-Star facility in quality.
- The SMR 30[1] improved.
- Patient length of stay improved.

Improved Efficiency Across the Facility

Facility System Redesign activities and accomplishments for FY 2015 included the following:

- Telephone responsiveness significantly improved with a decrease in the average speed to answer from 30 seconds to 9 seconds, and the call abandonment rate was reduced from 30 percent to 2.3 percent.
- HUD/VASH[2] voucher timeliness decreased the time it took for a veteran to have an appointment with the Public Housing Authority from an average of 2 weeks to 1 week.
- A prosthetics project reduced the manpower required to clean cardboard debris by 10 hours per week, removed approximately 2,000 pounds of scrap metal from the facility, and implemented a new process to clean motorized wheelchairs.

[1] Standardized 30-day mortality ratio.
[2] Housing and Urban Development/VA Supportive Housing

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, 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.		
	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.		

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 44 of 56 cases (79 percent) referred to Physician Utilization Management Advisors December 7, 2015–January 26, 2016, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**1.** 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 479 patient incidents reported in FY 2015 into the WEBSPOT database.	**2.** 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]

We inspected a medical unit, the surgical unit, the critical care unit, the Emergency Department, the OR, the community living center, the dental clinic, the locked MH unit, and a primary care clinic. Additionally, we reviewed relevant documents and 30 employee training records, 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
	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.		
	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
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• Two of seven patient care areas did not have personal protective equipment masks available on isolation carts.	**3.** We recommended that facility managers ensure the availability of personal protective equipment masks in all patient care areas and monitor compliance.
X	The facility met medication safety and security requirements.	• Three of seven patient care areas had unlocked medication cart drawers; expired medications; or undated, open multi-dose vials.	**4.** We recommended that employees secure medication carts when not in use, remove expired medications from patient care areas, and date multi-dose vials when opened and that facility managers monitor compliance.
	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.		
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.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
	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.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	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 10 pharmacy employees (6 pharmacists and 4 technicians). Additionally, we inspected the inpatient pharmacy where sterile products are compounded. 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 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
	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.		
	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.		
	The facility met design and environmental safety controls in compounding areas.		
	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.	**5.** 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.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	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. 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 that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and it 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.		
	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.		

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.		
	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.		
	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 patient 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 nine 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. 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		

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.		
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.	• There was no documentation of a CT scanner inspection by a medical physicist following three repairs or modifications that affected dose or image quality.	**6.** We recommended that a medical physicist complete and document inspections of computed tomography scanners following repair or modifications affecting dose or image quality 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.		
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 35 randomly selected patients who had an acute care admission from July 1, 2014, through June 30, 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
	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.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	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.		
	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 October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 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.

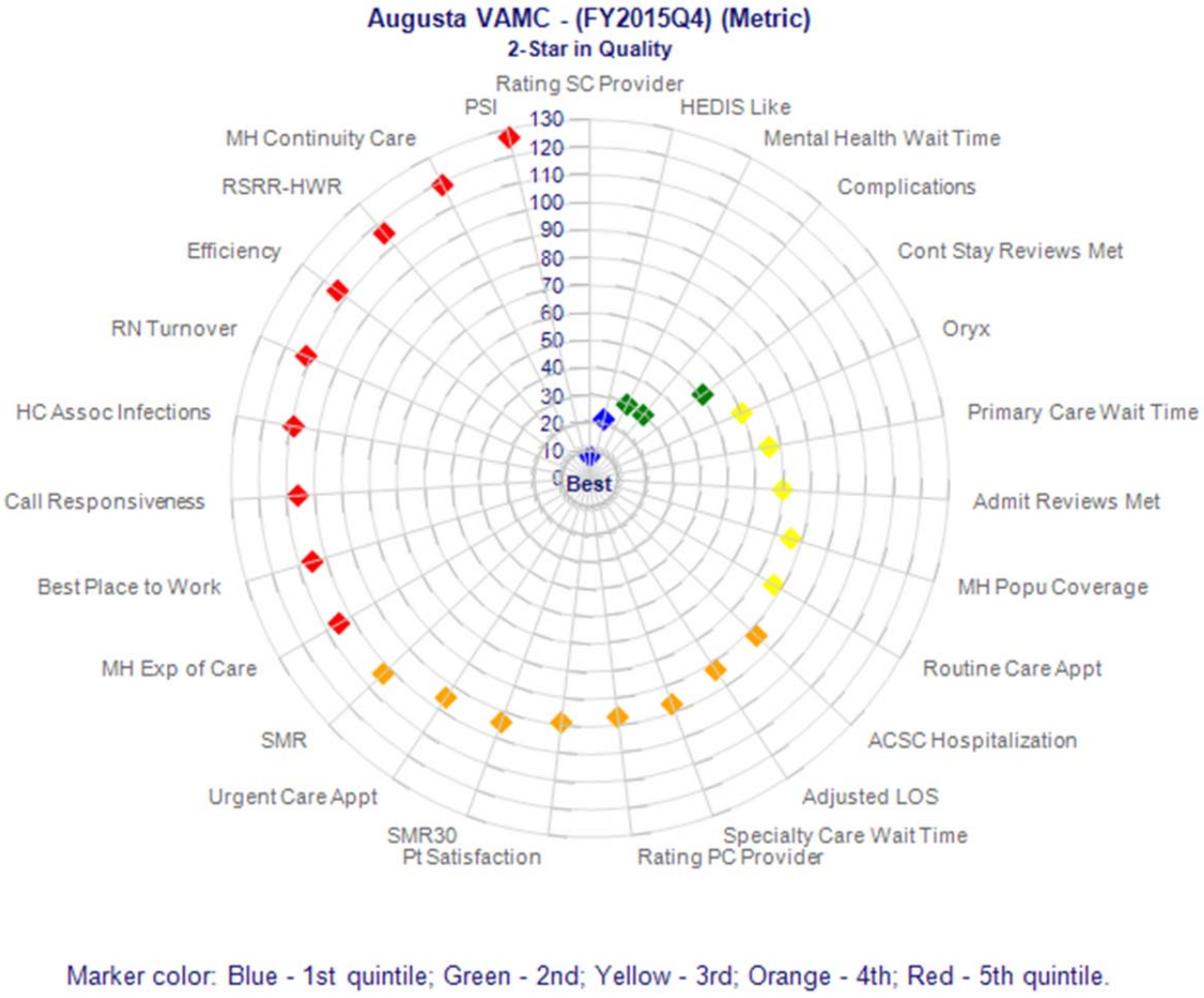
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk 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	• Six of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**7.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
X	The facility provided at least five suicide prevention outreach activities to community organizations each month.	• In the 3 months prior to the site visit, the Suicide Prevention Coordinator provided evidence of five outreach activities each month for only 2 of the 3 months.	**8.** We recommended that the Suicide Prevention Coordinator consistently provide at least five community outreach activities every month and that facility managers monitor compliance.
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		

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	• For one patient identified as high risk, clinicians did not document a Suicide Prevention Safety Plan during the admission.	**9.** We recommended that clinicians develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk and that facility managers monitor compliance.
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
X	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	• Two of the four applicable EHRs did not contain evidence that the treatment team followed up with patients at least four times during the first 30 days after discharge.	**10.** We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Augusta/509) FY 2016 through December 2015	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$111.5
Number of:	
• **Unique Patients**	28,268
• **Outpatient Visits**	127,960
• **Unique Employees**[3]	2,085
Type and Number of Operating Beds:	
• **Hospital**	255
• **Community Living Center**	132
• **Domiciliary**	60
Average Daily Census:	
• **Hospital**	131
• **Community Living Center**	80
• **Domiciliary**	51
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Athens/509GA Aiken/509GB
Veterans Integrated Service Network Number	7

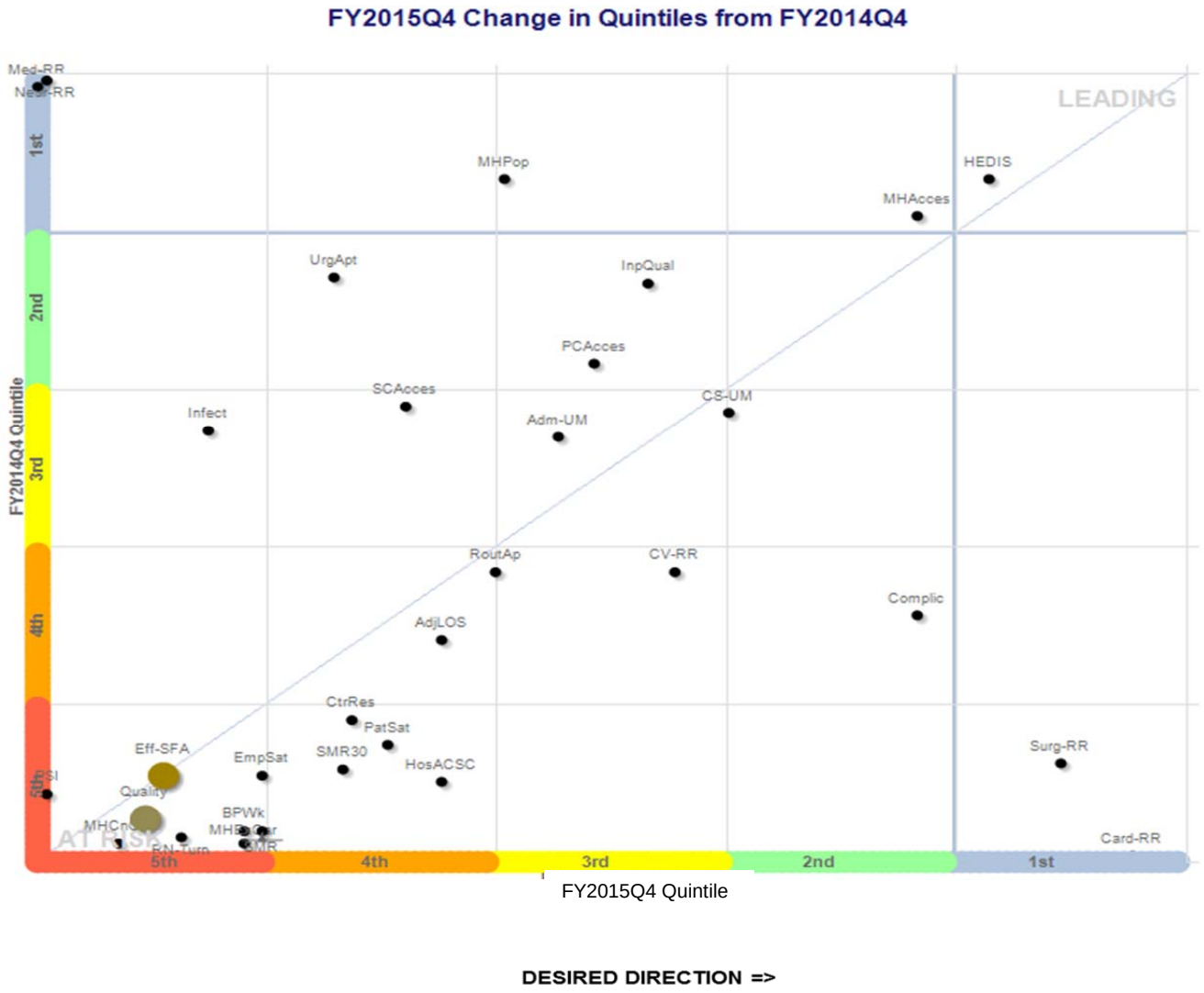
[3] Unique employees involved in direct medical care (cost center 8200).

SAIL[4]



[4] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2016

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Charlie Norwood VA Medical Center, Augusta, GA**

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

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

1. Please find the response to the Combined Assessment Program Review by the Office of the Inspector General Healthcare Inspection, conducted January 25–29, 2016, entitled "Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia."

2. I concur with the report and recommendations. Attached is the facility's Corrective Action Plan.

3. If you have any questions or need further information, please contact Donna Schnider, Quality Management Officer, at 678-924-5700.

Robin E. Jackson, Ph.D, LCSW

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2016

From: Director, Charlie Norwood VA Medical Center (509/00)

Subject: **CAP Review of the Charlie Norwood VA Medical Center, Augusta, GA**

To: Director, VA Southeast Network (10N7)

1. Please find the response to the Combined Assessment Program Review by the Office of the Inspector General Healthcare Inspection, conducted January 25–29, 2016, entitled "Combined Assessment Program Review of the Charlie Norwood VA Medical Center, Augusta, Georgia."

2. If you have any questions or concerns, please contact Clare O'Geary, RN, MSN, FACHE, Acting Chief, Quality Management at (706) 733-0188 extension 2105.

Maria R. Andrewes, MA, FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that 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: July 31, 2016

Facility response: The Physician Utilization Management Advisor (PUMA) review process will be strengthened so that all Utilization Manager's/Case Managers have access to the National Utilization Management Integration (NUMI) database and work with the PUMA's to achieve 90 percent compliance documentation of the reviews within 10 days of referral for 3 consecutive months. Monthly trends will be reported to senior leadership.

Recommendation 2. 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: May 31, 2016

Facility response: The Patient Safety coordinators will review all ePERs for FY 2015 with an Event Category of "Other" that were not entered into SPOT. They will be SAC scored and entered into SPOT. There are 479 ePERs that fall into this category. A bi-weekly report of progress will be provided to leadership.

Recommendation 3. We recommended that facility managers ensure the availability of personal protective equipment masks in all patient care areas and monitor compliance.

Concur

Target date for completion: March 14, 2016

Facility response: N-95 masks will be added to all secondary supply areas where negative pressure rooms are located. Surgical masks used for personal protective equipment are available in primary and secondary inventory locations. Stock levels will be reviewed according to established procedures and par levels adjusted as necessary.

Recommend for closure.

Recommendation 4. We recommended that employees secure medication carts when not in use, remove expired medications from patient care areas, and date multi-dose vials when opened and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: Pyxis education was provided to all Pharmacy staff, including training on checking and updating expired medications on February 19, 2016. Additional training is also underway on the ward inspection process to ensure increased compliance with removal of expired medications with expected completion by March 30, 2016.

Clinical Service Chiefs will review the policy on the dating multi-dose medications with all clinical staff and re-educate staff on securing medication carts when not in use. Monitoring through rounds and tracers will be conducted until 90 percent compliance is achieved for 3 consecutive months. Compliance will be reported to senior leadership.

Recommendation 5. 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: March 14, 2016

Facility response: The facility has procured sterile chemotherapy-type gloves and has submitted a request for sterile chemotherapy-type gloves to be added as a permanently stocked item for the Pharmacy staff use. Stock levels will be reviewed according to established procedures and par levels adjusted as necessary.

Recommend for closure.

Recommendation 6. We recommended that a medical physicist complete and document inspections of computed tomography scanners following repair or modifications affecting dose or image quality and that facility managers monitor compliance.

Concur

Target date for completion: March 14, 2016

Facility response: A medical physics contract was instituted with Alliance Medical Physics, LLC as of May 11, 2015 and all appropriate equipment inspections are performed yearly, and when equipment is prepared or modified. The contract covers all other medical physics requirements for the department. The Radiation Safety Committee has added a standing agenda item to address "new, moved, and repaired X-ray equipment" which will be reported through the committee minutes.

Recommend for closure.

Recommendation 7. 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: May 31, 2016

Facility response: The facility developed and deployed assignment profiles on February 15, 2016, to ensure that new employees are assigned suicide risk management training appropriate to their job code and tracked through the VA learning management system. Monitoring of completion of training will be reported to senior leadership. Currently there are 1,068 out of 1,140 assigned staff that have completed the suicide training course for a compliance score of 93 percent.

Recommend closure.

Recommendation 8. We recommended that the Suicide Prevention Coordinator consistently provide at least five community outreach activities every month and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Suicide Prevention Coordinator will continue to collaborate with the Outreach Committee to ensure compliance with the standard of 5 outreach activities per month. Outreach activities are entered monthly into the Suicide Prevention Program SharePoint (SPAN) and reported to National Suicide Prevention Program.

Monthly reports will be submitted to senior leadership until 100% compliance is reached for 3 consecutive months.

Recommendation 9. We recommended that clinicians develop Suicide Prevention Safety Plans during the admission for all patients identified as high risk and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Suicide Prevention coordinator/team will conduct suicide prevention safety plans on all high risk flagged patients prior to discharge. The plans will be documentation of the in CPRS and signed by the clinician prior to discharge. A statement related to suicide prevention safety plans was added the MD Discharge Summary template. Monthly chart audits will be conducted until 90% compliance is achieved for 3 consecutive months and compliance will be reported to senior leadership.

Recommendation 10. We recommended that treatment teams follow up with patients at least four times during the first 30 days after discharge and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Chief of Mental Health and the Suicide Prevention coordinator/team will provide additional training on the Enhanced Care Protocol, monitor high risk flagged patients for missed appointments, and conduct audits for high risk patients to ensure patients are seen at least 4 times within the first 30 days post discharge. Monthly chart audits will be conducted until 90 percent compliance is achieved for 3 consecutive months and compliance will be reported to senior leadership.

Office of Inspector General
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This report is available at **www.va.gov/oig**.

Endnotes

[a] The 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] The 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] The 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] 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] The 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] The 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.