Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00115-263

Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia

April 19, 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	Carl Vinson 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
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 22, 2016.

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

- Medication Management
- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were its waste management program, pharmacist led congestive heart failure clinics, and volunteer services.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Require Physician Utilization Management Advisors to consistently document their decisions in the National Utilization Management Integration database. Document Peer Review Committee monthly meetings.

Environment of Care: Ensure Environment of Care Committee meeting minutes reflect sufficient discussion of rounds deficiencies, corrective actions taken to address the deficiencies, and tracking of actions to closure. Require that operating room housekeepers complete initial training on cleaning and disinfection procedures.

Coordination of Care: Develop a policy that addresses temporary bed locations.

Advance Directives: Hold advance directive discussions requested by inpatients, and document the discussions.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within the required timeframe.

Mental Health Residential Rehabilitation Treatment Program: Consistently identify and document deficiencies concerning resident privacy, submit work orders for items needing repair, and document corrective actions taken for identified deficiencies. Consistently perform and document weekly inspections of resident rooms for contraband, rounds of all public spaces, and daily resident room inspections for unsecured medications. Require that the unit 10-B and unit 8-B main points of entry have keyless entry systems. Ensure that the closed circuit television system on unit 8-B has recording capabilities and that unit 10-B has signage alerting veterans and visitors of closed circuit television recording.

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 27–32, for the full text of the Directors' comments. We consider recommendation 11 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 eight activities:

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

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2015 and FY 2016 through February 22, 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 Carl Vinson VA Medical Center, Dublin, Georgia*, Report No. 13-02314-39, January 7, 2014). We made a repeat recommendation in MH RRTP.

During this review, we presented crime awareness briefings for 849 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 285 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

Waste Management Program

The facility's waste management program provides detailed instructions and visuals on how to properly dispose of medications, hazardous waste, flammables/corrosives, and controlled substances and provides the supplies for veterans to mail medical waste back to the facility. The program was recognized by the VISN as a best practice.

Pharmacist Led Congestive Heart Failure Clinics

Clinical pharmacy specialists in primary care conduct clinics for patients with a diagnosis of congestive heart failure. The pharmacists work within their scope of practice and are able to adjust/initiate medications; provide education; and assess patient diet, compliance with diet, and weight fluctuation. In the 18 months since the clinics began, the facility is one of the leading facilities in VISN 7 for improved patient outcomes.

Volunteer Services

The facility is fortunate to have strong support from community volunteers. The Honors Escort program, established last year, has been very successful. Additionally, through the generosity of volunteers, the number of veterans going to the Wheelchair Games and Golden Age Games this year has doubled.

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 227 of the 473 cases (48 percent) referred to Physician Utilization Management Advisors November 1, 2015–January 31, 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.
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
X	The facility met any additional elements required by VHA or local policy.	Facility policy requires the Peer Review Committee to meet monthly and document activities in meeting minutes. • Only 5 of 12 months of Peer Review Committee meetings had minutes documented.	**2.** We recommended that facility managers ensure Peer Review Committee monthly meetings are documented.

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 the intensive care and hospice units; two medical/surgical and two community living center units; the Emergency Department; the OR; the Women's Health Program area; and the Primary Care Blue Team, dental, and MH outpatient clinics. Additionally, we reviewed relevant documents and 15 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
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 facility and the community based outpatient clinics.	**3.** 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 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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
	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.		
	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.		
X	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.	• None of the five housekeepers assigned to the OR received initial training on cleaning and disinfection procedures.	**4.** We recommended that facility managers ensure operating room housekeepers complete initial training on cleaning and disinfection procedures.
	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.		
NA	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. Additionally, we inspected the area where sterile products are compounded. 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 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.		
	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.		

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. 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 that addressed patient discharge and scheduling discharges early in the day.		
X	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 did not have a policy that addressed temporary bed locations.	**5.** We recommended that the facility develop a policy that addresses temporary bed locations.
	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 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 four CT technologists and CT scanner inspection reports, and we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • 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.		
	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 July 1, 2014, through June 30, 2015. 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 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.		
NA	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
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.	• Seven of the 17 applicable EHRs did not contain documentation that employees held the discussions requested.	**6.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions 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 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 area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	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	• Four 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.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
NA	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians 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		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
NA	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.		

MH RRTP

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

We reviewed relevant documents; inspected the Domiciliary Care for Homeless Veterans Program female unit 10-B and male unit 8-B, Substance Abuse RRTP, and the Post-Traumatic Stress Disorders RRTP; and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of self-inspection documentation reviewed: • MH RRTP employees did not consistently identify and/or document deficiencies concerning resident privacy, submit work orders for items needing repair, and document corrective actions taken for identified deficiencies.	**8.** We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently identify and document deficiencies concerning resident privacy, submit work orders for items needing repair, and document corrective actions taken for identified deficiencies and that program managers monitor compliance.

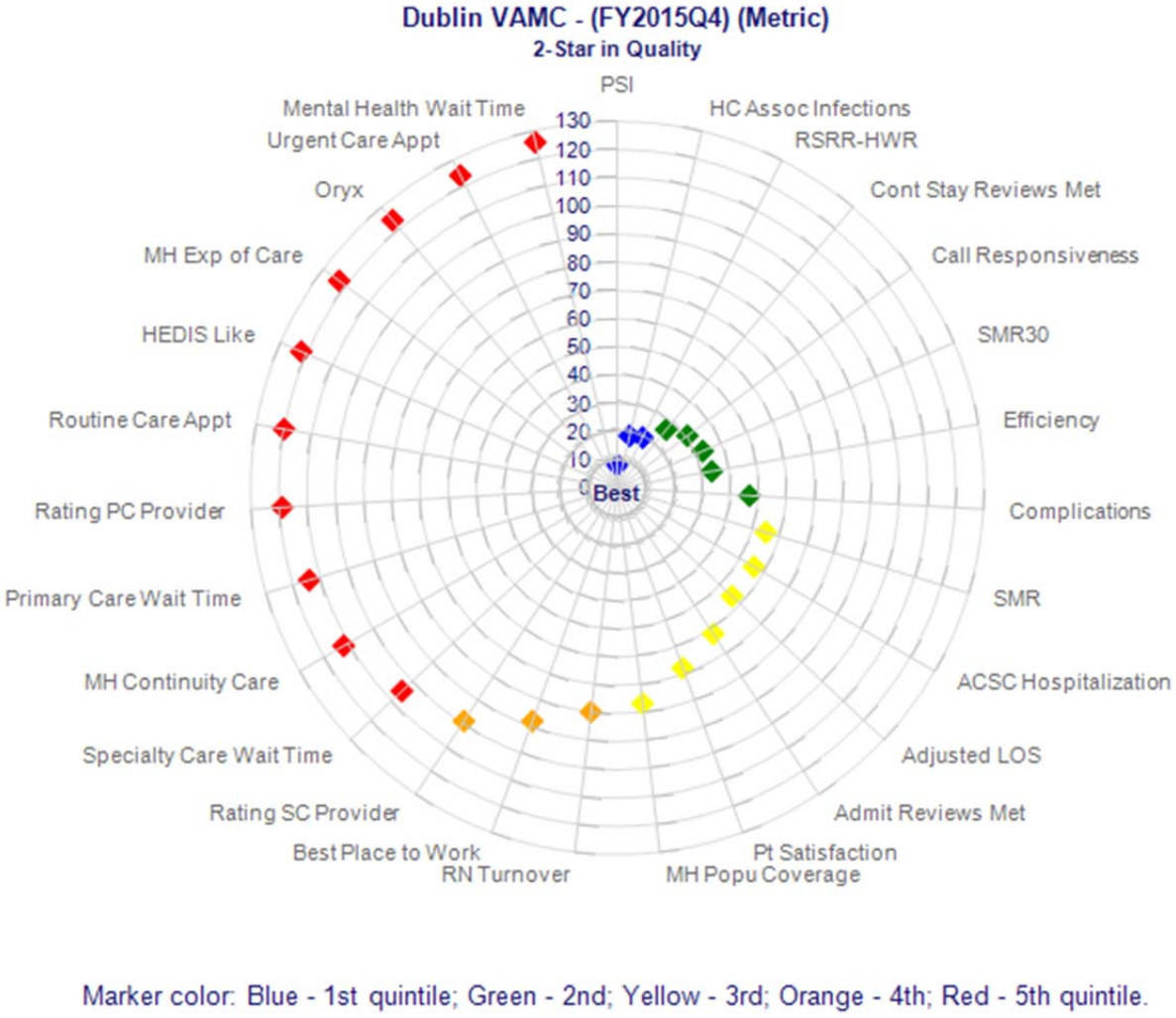
NM	Areas Reviewed (continued)	Findings	Recommendations
X	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.	• For the month of January 2016, there was no documentation of weekly inspections of a minimum of 10 percent of resident rooms for contraband. This was a repeat finding from the previous CAP review. • For the 10-day period February 7–17, 2016, MH RRTP employees did not consistently document 2-hour rounds of all public spaces. • For January 18–31, 2016, there was no documentation of daily resident room inspections for unsecured medications.	**9.** We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently perform and document weekly inspections of a minimum of 10 percent of resident rooms for contraband, 2-hour rounds of all public spaces, and daily resident room inspections for unsecured medications and that program managers monitor compliance.
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
X	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• Unit 10-B and unit 8-B did not have a keyless entry system on the main point of entry to the units. This was a repeat finding from the previous CAP review.	**10.** We recommended that the unit 10-B and unit 8-B main points of entry have keyless entry systems.
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.	• The closed circuit television system on unit 8-B did not have recording capabilities. • Unit 10-B did not have signage alerting veterans and visitors of closed circuit television recording.	**11.** We recommended that facility managers ensure that the closed circuit television system on unit 8-B have recording capabilities and that unit 10-B have signage alerting veterans and visitors of closed circuit television recording.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
NA	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Dublin/557) FY 2016 through February 2016	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$227.8
Number of:	
• **Unique Patients**	28,171
• **Outpatient Visits**	148,041
• **Unique Employees**[1]	1,019
Type and Number of Operating Beds:	
• **Hospital**	34
• **Community Living Center**	147
• **Domiciliary**	145
Average Daily Census:	
• **Hospital**	12
• **Community Living Center**	135
• **Domiciliary**	94
Number of Community Based Outpatient Clinics	5
Location(s)/Station Number(s)	Macon/557GA Albany/557GB Milledgeville/557GC Brunswick/557GE Kathleen/557HA
VISN Number	7

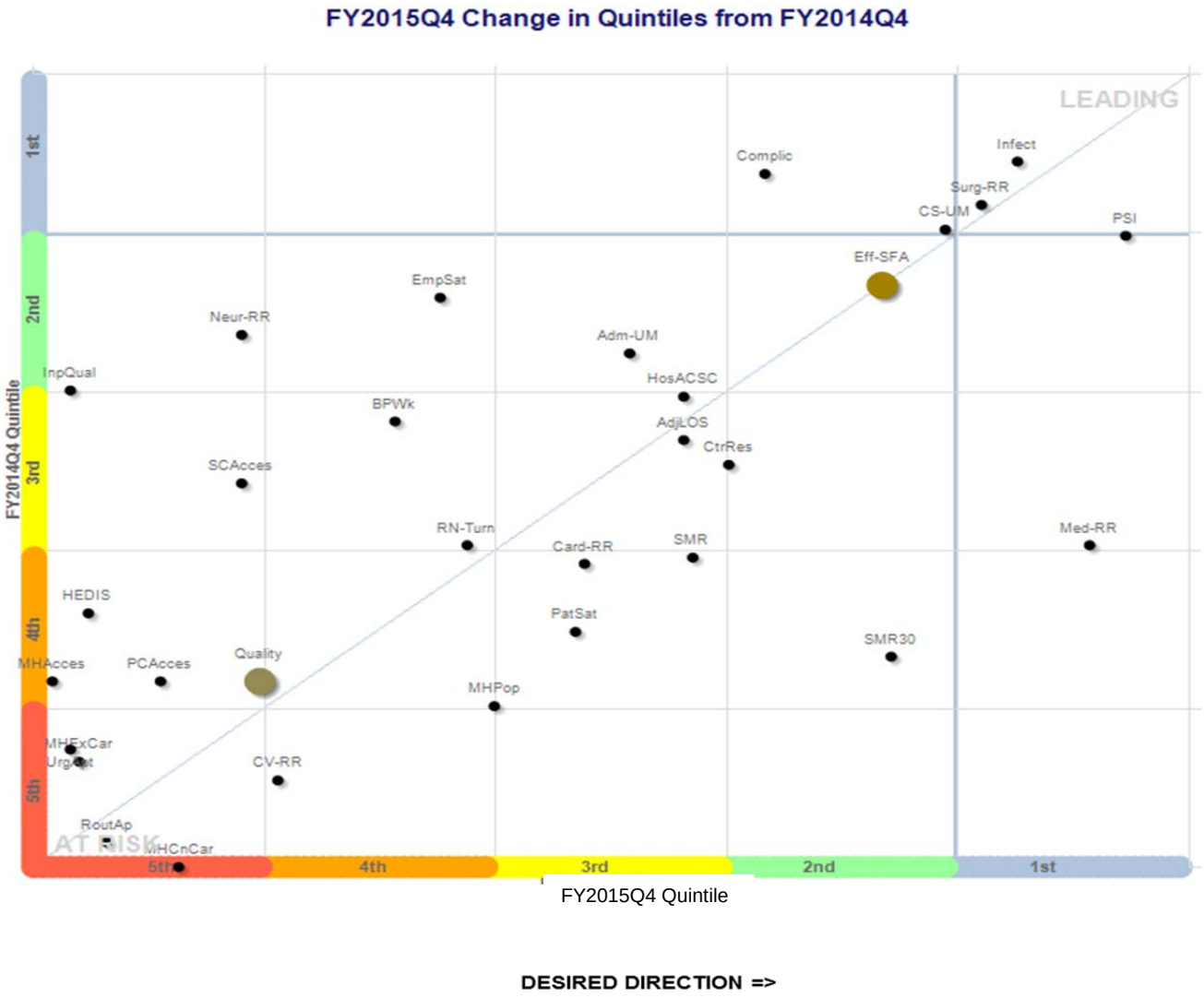
[1] Unique employees involved in direct medical care (cost center 8200).

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



[2] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

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

Metric Definitions

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 24, 2016

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Carl Vinson VA Medical Center, Dublin, GA**

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

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

1. Thank you for the opportunity to review the draft report of OIG Combined Assessment Program Review – Dublin GA (54SP).

2. I concur with the report and recommendations. Attached is the facility's corrective action plan for cited recommendations.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact Donna Schnider, VISN 7 Quality Management Officer, at 678-924-5700.

Leslie Wiggins
Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 24, 2016

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **CAP Review of the Carl Vinson VA Medical Center, Dublin, GA**

To: Director, VA Southeast Network (10N7)

1. I concur with the recommendations presented in the Combined Assessment Program Review of the Carl Vinson VA Medical Center.

2. Thank you for this opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations.

3. If you have additional questions or need further information, please contact me at (478)-272-1210, ext. 2901.

Maryalice Morro, RN, MSN
Director, Carl Vinson VA Medical Center (557/00)

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: June 2016

Facility response: Physician Utilization Management Advisors (PUMA) has been trained. Utilization Management (UM) Coordinator will perform monthly Chart Review Audits beginning in March 2016 for three (3) months. UM Coordinator will provide updates to Quality Leadership Team (QLT) on a monthly basis. The UM Coordinator will provide updates on the percentage of PUMA's completed monthly at QLT.

Recommendation 2. We recommended that facility managers ensure Peer Review Committee monthly meetings are documented.

Concur

Target date for completion: April 1, 2016

Facility response: Standing Peer Review Committee meeting is held on a monthly basis. This began in December 2015. Minutes are completed and approved prior to the next PRC committee meeting. This committee reports to the Medical Executive Committee (MEC) on a quarterly basis.

Recommendation 3. 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 facility and the community based outpatient clinics.

Concur

Target date for completion: June 2016

Facility response: First EOC meeting since OIG was held in March 2016; action items are now being identified and tracked by the Safety Manager. Safety Manager will report findings to QLT on a monthly basis.

Recommendation 4. We recommended that facility managers ensure operating room housekeepers complete initial training on cleaning and disinfection procedures.

Concur

Target date for completion: April 1, 2016

Facility response: All initial training will be completed by April 2016 and EMS Service Chief will monitor for three (3) months to ensure compliance. EMS Chief will report monthly to QLT.

Recommendation 5. We recommended that the facility develop a policy that addresses temporary bed locations.

Concur

Target date for completion: April 29, 2016

Facility response: MCM 00/CCC- Temporary Bed Location policy has been drafted and routing through facility leadership for review and approval. Anticipated date of approval of MCM is April 29, 2016.

Recommendation 6. We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: Creation of work group to address deficient areas:

- Revision of the local facility Advance Directive
- Review of current templates (nursing initial screening, advance directive templates, IDT Care Plans, etc.)
- CWAD Posting
- Education (nurses, physicians, and social workers)

Work group will report out to QLT monthly on progress. Compliance chart audits will begin in July 2016 and will report monthly to QLT.

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: April 30, 2016

Facility response: Training for new employees will be completed every Friday of the week of New Employee Orientation (NEO) expected to start on March 25, 2016. All current employees deficient in training will be trained by April 30, 2016.

Recommendation 8. We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently identify and document deficiencies concerning resident privacy, submit work orders for items needing repair, and document corrective actions taken for identified deficiencies and that program managers monitor compliance.

Concur

Target date for completion: April 16, 2016

Facility response: Employees will be re-trained on documentation for consistency and accuracy. Environment of Care form will be revised to ensure clarity of privacy, safety and security. This form is completed monthly by staff and reported to Safety officer.

Recommendation 9. We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently perform and document weekly inspections of a minimum of 10 percent of resident rooms for contraband, 2-hour rounds of all public spaces, and daily resident room inspections for unsecured medications and that program managers monitor compliance.

Concur

Target date for completion: April 15, 2016

Facility response: Employees will be re-trained on documentation for consistency and accuracy. A minimum of 10 percent of total weekly inspections will be monitored by the DOM Chief for a period of 3 months to ensure documentation is reflective of the weekly inspections being performed. Employees were retrained on February 24, 2016 to review documentation for consistency and accuracy. Daily two (2) hour inspection form was revised to ensure clear expectations including a space for comments.

This process will be incorporated into SOP by April 15, 2016.

Recommendation 10. We recommended that the unit 10-B and unit 8-B main points of entry have keyless entry systems.

Concur

Target date for completion: April 16, 2016

Facility response: Unit 8B has keyless entry lock system in place. Acquisition package will be drafted to purchase a keyless entry system for Unit 10B and will be submitted to contracting by March 28, 2016.

Recommendation 11. We recommended that facility managers ensure that the closed circuit television system on unit 8-B have recording capabilities and that unit 10-B have signage alerting veterans and visitors of closed circuit television recording.

Concur

Target date for completion: Completed. No further monitoring required.

Facility response: Appropriate signage alerting veterans and visitors that the closed circuit television system has recording capabilities has been put in place on Unit 8B and 10B. Both 8B and 10B have a closed-circuit TV system with recording capabilities.

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] 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.

[h] The references used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.