Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00111-310

Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana

May 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	Richard L. Roudebush 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

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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 March 7, 2016.

Review Results: The review covered eight activities. The facility's reported accomplishment was a veterans' sound off board.

Recommendations: We made recommendations in all eight of the following activities:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months. Ensure the Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOT database.

Environment of Care: Ensure Environment of Care Board meeting minutes include corrective actions taken to address rounds deficiencies. Require all health care occupancy buildings to have at least one fire drill per shift per quarter. Repair damaged furniture in patient care areas, or remove it from service. Properly cover medical waste/biohazard containers. Promptly remove expired medications from patient care areas, and date multi-dose medication vials when opened. Ensure all sharps containers are closed. Require all dental clinic employees to complete hazard communication training on chemical classification, labeling, and safety data sheets. Consistently monitor operating room temperature, humidity, and positive pressure. Ensure all operating room exits are unobstructed.

Medication Management: Revise the competency assessment policy for employees who prepare compounded sterile products to include the required intervals for gloved fingertip sampling. Revise the compounded sterile products safety/competency assessment checklist to include donning of personal protective equipment in the required order and the performance of appropriate hand hygiene after personal protective equipment removal.

Coordination of Care: Revise the patient discharge policy to include scheduling discharges early in the day. Revise the temporary bed locations policy to include priority placement for inpatient beds given to patients in temporary bed locations. Document transfer notes and transfers.

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.

Advance Directives. Consistently correctly post patients' advance directives status. Ask inpatients whether they would like to discuss creating, changing, and/or revoking 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. Include in Suicide Prevention Safety Plans assessment of available lethal means and how to keep the environment safe. Ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan.

Mental Health Residential Rehabilitation Treatment Program: Ensure the program area is clean, and repair or replace identified items. Correct the deficiencies identified, and ensure documentation reflects correction. Ensure closed circuit television monitors with recording capability are available in public areas but not in treatment areas. Ensure exit signs are visible.

Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 28–39, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives

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

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

Scope

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

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following 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 March 11, 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 Richard L. Roudebush VA Medical Center, Indianapolis, Indiana*, Report No. 13-02316-322, September 23, 2013). We made a repeat recommendation in EOC.

During this review, we presented crime awareness briefings for 122 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 758 responses. We shared summarized results with facility managers.

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

Reported Accomplishment

Veterans' Sound Off Board

In collaboration with the Patient Advisory Council, the facility created a veterans' sound off board, also referred to as a huddle board. The board gives veterans and their family members a place to voice ideas, suggestions, compliments, and concerns on an ongoing basis. A veteran or family member writes his or her idea, suggestion, or concern on a yellow form provided at the huddle board and places it in a locked box. A designated employee from the Office of Patient Centered Care retrieves the completed forms daily. A facility employee follows up with the person directly to thank him or her for the input and to communicate the next step in the process. The facility attaches a response to the yellow form and places it in the appropriate section on the huddle board—New Improvement Ideas, Ideas in Progress, Ideas Completed, or Compliment. Any personal contact information on the yellow form is removed prior to the form being placed on the board for others to view.

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.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Three profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
	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.		
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 patient incidents reported from April to September 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 the Emergency Department, four inpatient medical-surgical units (7A North, 7A South, 8A North, and 8A South), the MH inpatient unit, two primary care clinics (Blue and Green), one specialty clinic, the medical intensive care unit, the surgical intensive care unit, the dental clinic, and the OR. Additionally, we reviewed relevant documents and 17 employee training records (10 dental clinic and 7 OR), 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 Board meeting minutes reviewed: • Minutes did not include corrective actions taken to address rounds deficiencies. This was a repeat finding from the previous CAP review.	**3.** We recommended that Environment of Care Board meeting minutes include corrective actions taken to address rounds deficiencies.
	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.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Two quarters of fire drill documentation for health care occupancy buildings reviewed: • All applicable buildings did not have at least one fire drill per shift per quarter.	**4.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

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.		
X	The facility met environmental safety requirements.	• Two of 11 patient care areas contained damaged furniture.	**5.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service.
X	The facility met infection prevention requirements.	• In 9 of 11 patient care areas, medical waste/biohazard containers were not properly covered.	**6.** We recommended that facility managers ensure medical waste/biohazard containers are properly covered and monitor compliance.
X	The facility met medication safety and security requirements.	• Two of 11 patient care areas had expired medications. • Six of 11 patient areas had undated, opened multi-dose medication vials.	**7.** We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance. **8.** We recommended that employees date multi-dose medication vials when opened and that facility managers monitor compliance.
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	OSHA standard on bloodborne pathogens reviewed, which requires sharps containers to be closed. • Three sharps containers in the specialty clinic were not closed.	**9.** We recommended that facility managers ensure all sharps containers are closed and monitor compliance.
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
X	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.	• Two of 10 dental clinic employees did not have documentation of hazard communication training on chemical classification, labeling, and safety data sheets.	**10.** We recommended that dental clinic managers ensure all dental clinic employees complete hazard communication training on chemical classification, labeling, and safety data sheets and monitor compliance.
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.		
	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.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
X	The facility monitored OR temperature, humidity, and positive pressure.	• The facility did not monitor temperature, humidity, or positive pressure in the OR.	**11.** We recommended that facility managers ensure consistent monitoring of operating room temperature, humidity, and positive pressure.
X	The facility met fire safety requirements in the OR.	• One of three OR exits was obstructed.	**12.** We recommended that facility managers ensure all operating room exits are unobstructed and monitor compliance.
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
X	The facility met medication safety and security requirements in the OR.	• There was one undated, opened multi-dose medication vial in the OR anesthesia workroom.	See recommendation 8.
	The facility met laser safety requirements in the OR.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	• Five sharps containers in the OR were not closed.	See recommendation 9.

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 (5 pharmacists and 5 technicians). Additionally, we inspected one area where sterile products are compounded. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Facility competency assessment policy for employees who prepare CSPs did not include the required intervals for gloved fingertip sampling.	**13.** We recommended that the facility revise the competency assessment policy for employees who prepare compounded sterile products to include the required intervals for gloved fingertip sampling.

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		
X	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.	• The facility's CSP safety/competency assessment checklist did not include the donning of personal protective equipment in the required order and the performance of appropriate hand hygiene after personal protective equipment removal.	**14.** We recommended that the facility revise the compounded sterile products safety/competency assessment checklist to include donning of personal protective equipment in the required order and the performance of appropriate hand hygiene after personal protective equipment removal.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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		

NM	Areas Reviewed (continued)	Findings	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.	• Facility policy did not address scheduling patient discharges early in the day.	**15.** We recommended that the facility revise its policy for patient discharge to include 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's temporary bed locations policy did not include priority placement for inpatient beds given to patients in temporary bed locations.	**16.** We recommended that the facility revise its temporary bed locations policy to include priority placement for inpatient beds given to patients in 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.		
X	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.	• For four of the seven applicable EHRs, physicians did not document transfer notes. • For five of the eight applicable EHRs, receiving physicians did not document the transfer.	**17.** We recommended that physicians document transfer notes and that facility managers monitor compliance. **18.** We recommended that receiving physicians document transfers and that facility managers monitor compliance.
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

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

We reviewed relevant documents, including qualifications and dosimetry monitoring for eight CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance. • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer. • A process for managing/reviewing CT protocols and procedures to follow when revising protocols. • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans.		

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 one repair or modification that affected dose or image quality.	**19.** 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.		
	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 29 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For five of the 29 EHRs, employees did not correctly post patients' AD status.	**20.** We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Four of the 29 EHRs did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs. • Two of the four applicable EHRs did not contain documentation that employees held the discussions requested.	**21.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance. **22.** 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 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.	• Five of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**23.** We recommended that the facility ensure new clinical employees complete suicide risk management training within the required timeframe and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
X	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs. • Identification of internal coping strategies. • Identification of contact numbers of family or friends for support. • Identification of professional agencies. • Assessment of available lethal means and how to keep the environment safe.	• Eleven of the 40 safety plans (28 percent) lacked documentation of the identification of assessment of available lethal means and how to keep the environment safe.	**24.** We recommended that clinicians include assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• In eight of the 40 applicable EHRs (20 percent), clinicians did not document that they gave patients and/or caregivers a copy of the plan.	**25.** We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans Program complied with selected EOC requirements.[h]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

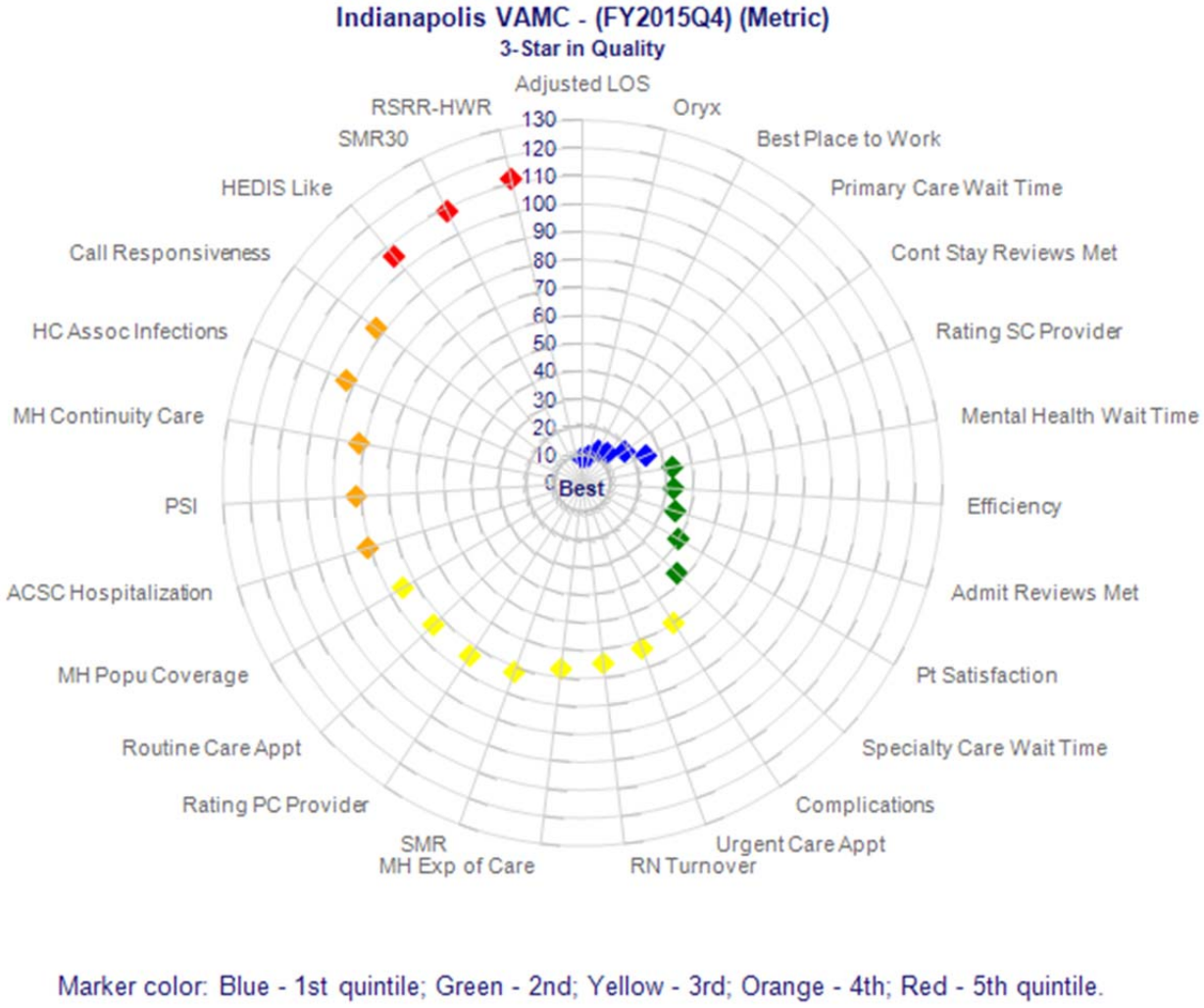
NM	Areas Reviewed	Findings	Recommendations
X	The residential environment was clean and in good repair.	• The program had: o Dirty and unkempt resident rooms and dirty stairways o Stained, loose, and missing ceiling tiles o Loose window frames with missing and chipped paint	**26.** We recommended that facility managers ensure the Domiciliary Care for Homeless Veterans Program is clean and monitor compliance. **27.** We recommended that the facility repair or replace identified items in the Domiciliary Care for Homeless Veterans Program.
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.	Seven months of self-inspection documentation reviewed: • Documentation did not reflect correction of three identified deficiencies in the program.	**28.** We recommended that the facility correct the deficiencies identified in the Domiciliary Care for Homeless Veterans Program and that documentation reflects correction.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	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.		
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 program did not have closed circuit television monitors with recording capability in public areas and had closed circuit television monitors installed in treatment areas.	**29.** We recommended that facility managers ensure the Domiciliary Care for Homeless Veterans Program has closed circuit television monitors with recording capability in public areas and does not have monitors installed in treatment areas.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
X	The facility complied with any additional elements required by VHA or local policy.	Joint Commission standards reviewed, which require exit signs to be visible when the path to the exit is not readily apparent: • On one of the two resident floors, the exit sign was occluded from view.	**30.** We recommended that facility managers ensure exit signs on Domiciliary Care for Homeless Veterans Program resident floors are visible.

Facility Profile (Indianapolis/583) FY 2016 through February 2016	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$491.3
Number of:	
• **Unique Patients**	47,974
• **Outpatient Visits**	306,433
• **Unique Employees**[1]	2,568
Type and Number of Operating Beds:	
• **Hospital**	159
• **Community Living Center**	NA
• **Domiciliary**	50
Average Daily Census:	
• **Hospital**	103
• **Community Living Center**	NA
• **Domiciliary**	42
Number of Community Based Outpatient Clinics[2]	3
Location(s)/Station Number(s)	Terre Haute/583GA Bloomington/583GB Martinsville/583GC
Veterans Integrated Service Network Number	10

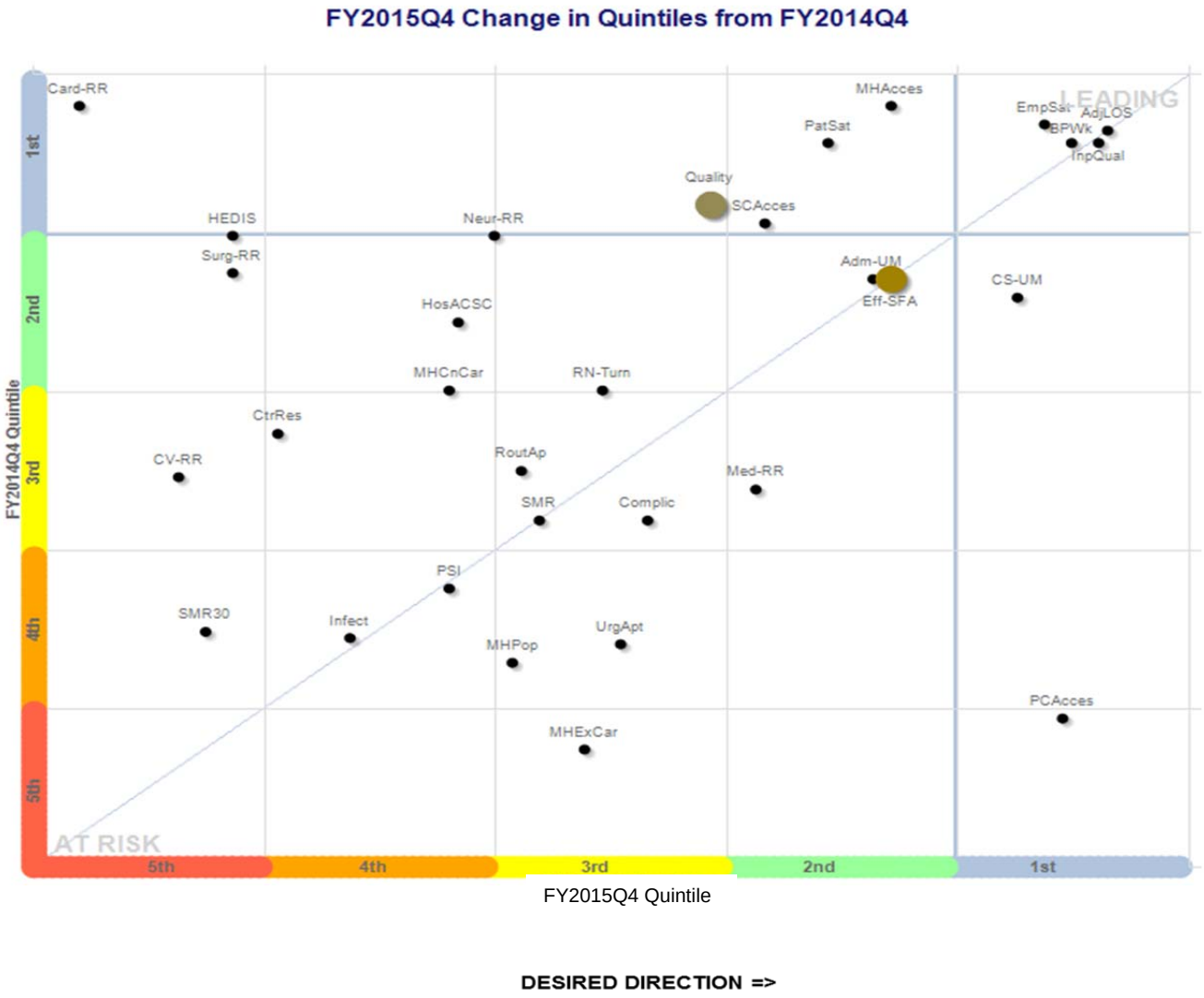
[1] Unique employees involved in direct medical care (cost center 8200).
[2] We have omitted 583QA (Bloomington), 583QB (Indianapolis), 583QC (Terra Haute), and 583GD (Indianapolis) as no workload/encounters or services were reported.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

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

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: April 29, 2016

From: Acting Director, VA Healthcare System (10N10)

Subject: CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. Please find attached responses to CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN. I concur with the Medical Center Director's response.

2. If you have any questions, please contact Vickie Montague, VISN 10 Quality Management Officer at 216-791-2300 x5305.

for Robert P. McDivitt, FACHE

Attachment

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 22, 2016

From: Acting Director, Richard L. Roudebush VA Medical Center (583/00)

Subject: CAP Review of the Richard L. Roudebush VA Medical Center, Indianapolis, IN

To: Acting Director, VA Healthcare System (10N10)

This memorandum serves as our concurrence with the recommendations found in the draft report of the Inspector General Combined Assessment Program (CAP) at the Richard L. Roudebush VA Medical Center.

I appreciate the opportunity for this review as a continuous process to improve the care to our Veterans. If you require additional information, please contact Patricia Calvin, Chief, Clinical Excellence (Quality) at 317-988-2421.

Thank You

Bashir, Chowdry M. Digitally signed by Bashir, Chowdry M. DN: dc=gov, dc=va, ou=Entities, ou=Internal/Staff, cn=Bashir, Chowdry M. Date: 2016.04.26 12:43:01 -04'00'

Dr. Chowdry Bashir

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Clinical Service Chiefs will complete Ongoing Professional Practice Evaluation (OPPE) within 30 days after OPPE rating cycle has ended. Clinical Service Chiefs will attest to completion via memorandum to Credentialing Chief and provide access to OPPE files for review. Credentialing Chief will review OPPE files within 15 days of OPPE completion. Outliers/unmet benchmarks will be discussed and reviewed with Service Chief and reported to the Professional Standards Board/Executive Committee of the Medical Staff (PSB/ECMS) meetings. Notification of new process to Clinical Service Chiefs will take place at PSB/ECMS meeting on May 4, 2016. Monitoring will be ongoing every six months with outliers reported monthly to PSB/ECMS.

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: September 30, 2016

Facility response: Effective April 6, 2016, the Patient Safety Specialist has dedicated two (2) hours per day Monday through Friday to entering patient incidents into Web Spot to eliminate the backlog by June 15, 2016. The Service Chief will receive a status report on the number of outstanding incidents and will receive a status report monthly after backlog is eliminated to ensure sustainability.

Recommendation 3. We recommended that Environment of Care Board meeting minutes include corrective actions taken to address rounds deficiencies.

Concur

Target date for completion: September 30, 2016

Facility response: Areas responsible for the top three consistent deficiencies will be required to submit a monthly action plan beginning May, 2016. An annual report will be required from EMS beginning in August, 2016 and the committee will review the annual report and identify the top two areas of focus for the upcoming fiscal year where trending and monitoring will be reported.

Recommendation 4. We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: On April 6, 2016 the Chief of Safety revised the hospital fire drill schedule to include healthcare occupancy areas for future drill sites. Drills will be conducted 12 times per year to capture each shift per quarter. The fire drill Standard Operating Procedure (SOP) was revised and discussed with the Safety Technician on April 15, 2016. The Safety office has an electronic list of fire drills that will annotate the date and type of occupancy for that specific drill. Information will be reported to the Environment of Care Board quarterly.

Recommendation 5. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: May 1, 2016

Facility response: Upon receipt of notification of damaged furniture, engineers and Interior Designers will assess the furniture. If repairable, Engineering Service will initiate a work order and accomplish repairs. If the furniture cannot be repaired it will be removed from use and replacement initiated. Engineering Service submitted a request for facility staff to assess furniture in their areas and notify Engineering if there are damaged items to be included in the employee weekly e-mail newsletter on April 15, 2016. This is an ongoing process to ensure furniture is acceptable and safe for use.

Recommendation 6. We recommended that facility managers ensure medical waste/biohazard containers are properly covered and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Environmental Management Service (EMS) Chief has initiated ordering medical/waste biohazard containers operated by a foot pedal allowing for automatic closure once pressure is released from the foot pedal. On March 17, 2016, training was provided to the EMS staff on proper covering of medical waste/biohazard containers. Just in Time training is provided to staff in the area if the medical waste/biohazard container lid is found open. This will be an ongoing facility monitor.

Recommendation 7. We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Inpatient and Outpatient Managers are responsible for assigning unit-specific monitoring to observe medication storage areas for compliance with the removal of expired medications from clinical areas. Just in Time education and training will be provided, if applicable. Monthly compliance rate will be shared at the Clinical Performance Board (CPB) meeting.

Recommendation 8. We recommended that employees date multi-dose medication vials when opened and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Inpatient and Outpatient Managers are responsible for assigning unit-specific monitoring to observe medication storage areas. This is to ensure compliance with the removal of expired medications from clinical areas. Just in Time education and training will be provided, if applicable. Monthly compliance rate will be shared at the Clinical Performance Board meeting.

Recommendation 9. We recommended that facility managers ensure all sharps containers are closed and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: All identified sharp containers were replaced by April 8, 2016. The vendor Stericycle/EIE will monitor for compliance twice weekly and ensure that container dollies are intact. EMS staff will monitor compliance weekly and report to the Environment of Care (EOC) Board quarterly. This will be an ongoing facility monitor.

Recommendation 10. We recommended that dental clinic managers ensure all dental clinic employees complete hazard communication training on chemical classification, labeling, and safety data sheets and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Dental Residents and Consultants who had not taken part in the online training received a hard copy of the TMS module. Documentation was received via e-mail or signed print version by all identified staff indicating review and completion of the module. The review process via paper record began the week of March 7, 2016 and concluded on April 12, 2016 resulting in 100% compliance. The Dental Business Manager will run a quarterly report to verify compliance and sustainment of completion of hazard communication training module.

Recommendation 11. We recommended that facility managers ensure consistent monitoring of operating room temperature, humidity, and positive pressure.

Concur

Target date for completion: August 31, 2016

Facility response: Pressure is monitored and maintained through yearly testing and balancing for appropriate pressure differential by adjusting supply and return air flow volumes. Humidity management in the Operating Room (OR) is monitored by Engineering. The current system allows for minor temperature manipulation and adjusting reheat temperatures to control humidity. Temperature in the OR is set per guidelines and managed by the OR staff per surgeon and type of procedure being performed while staying within the established guidelines. The OR staff notifies Engineering Service if the digital temperature read is out of range. The facility is in the process of updating/installing a system to allow for improved monitoring of the OR rooms for temperature, humidity, and positive pressure. The work is in progress and expected to be completed in two to three months. After work is completed, the OR staff will meet with Engineering Service for education/training related to the operating system and role clarification for monitoring and tracking conditions in the OR rooms.

Recommendation 12. We recommended that facility managers ensure all operating room exits are unobstructed and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The OR staff worked with EMS to develop a daily rounding process on March 23, 2016 to monitor for egress in the OR areas. When egress is noted, OR

staff will remove the item(s) if applicable to their service or contact the service responsible for immediate removal. Quality Management staff will perform additional egress tracers in the OR area and provide results to the service responsible. Reports will be provided monthly to the CPB. This will be an ongoing facility monitor to ensure all exits are unobstructed.

Recommendation 13. We recommended that the facility revise the competency assessment policy for employees who prepare compounded sterile products to include the required intervals for gloved fingertip sampling.

Concur

Target date for completion: May 6, 2016

Facility response: The Competency Assessment Policy will be revised to reflect the approved practices via USP 797. This is only a document change as the practice is in compliance with USP 797. This will be completed by April 29, 2016 and reviewed at Pharmacy Service huddles. No monitoring necessary.

Recommendation 14. We recommended that the facility revise the compounded sterile products safety/competency assessment checklist to include donning of personal protective equipment in the required order and the performance of appropriate hand hygiene after personal protective equipment removal.

Concur

Target date for completion: May 6, 2016

Facility response: The compounded sterile products safety and competency assessment checklist will be revised to reflect the approved practices via USP 797. This is only a document change as the practice is in compliance with USP 797. This will be completed by April 29, 2016 and reviewed at Pharmacy Service Huddles. No monitoring necessary.

Recommendation 15. We recommended that the facility revise its policy for patient discharge to include scheduling discharges early in the day.

Concur

Target date for completion: June 30, 2016

Facility response: The facility policy, “Discharge Planning,” will be revised to include guidance for staff to make every effort to discharge patients before 10:00 a.m. daily.

Recommendation 16. We recommended that the facility revise its temporary bed locations policy to include priority placement for inpatient beds given to patients in temporary bed locations.

Concur

Target date for completion: April 8, 2016

Facility response: The facility's policy "Patient Admission" has been updated to indicate priority bed placement is given to those being held in the Emergency Department (ED) due to lack of bed availability on the ward or in the intensive care unit.

Recommendation 17. We recommended that physicians document transfer notes and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Required documentation for inter-facility transfers will be communicated to inpatient providers by May 6, 2016 via e-mail. Monthly random chart audits will be conducted on patients who had a transfer during the review month to validate documentation by receiving and sending physician. This will be performed by the Medicine Service staff and reported quarterly to the Executive Committee for the Medical Staff (ECMS) meeting.

Recommendation 18. We recommended that receiving physicians document transfers and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Required documentation for inter-facility transfers will be communicated to inpatient providers by May 6, 2016 via e-mail. Monthly random chart audits will be conducted on patients who had a transfer during the review month to validate documentation by receiving and sending physician. This will be performed by the Medicine Service staff and reported quarterly to the Executive Committee for the Medical Staff (ECMS) meeting.

Recommendation 19. 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: September 30, 2016

Facility response: The facility updated the Radiographic Equipment Tube Inspection list to include the Medical Physicist's review of the equipment to indicate ready for use following repair and/or modification. This revision to the template was completed July 2015. The Equipment Tube Inspection list will be reviewed monthly to ensure documentation is noted and post any repair to equipment reported to the Radiation Safety Committee.

Recommendation 20. We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Inpatient and Outpatient staff were re-educated on documentation of Advance Directive screening criteria beginning on April 25, 2016 and completed by May 31, 2016 to account for staff on leave. The Inpatient Social Worker will perform a monthly review of 20 random admission records to validate the most recent advance directive discussion/status is posted. Outliers will be communicated to staff involved in the episode of care and monthly to the CPB. Upon achieving 90% compliance for two consecutive quarters, the monitoring and reporting to the CPB will occur quarterly to ensure sustainment.

Recommendation 21. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: Inpatient and Outpatient staff were re-educated on documentation of Advance Directive screening criteria beginning on April 25, 2016 and completed by May 31, 2016 to account for staff on leave. The Inpatient Social Worker will perform a monthly review of 20 random admission records to validate the most recent advance directive discussion/status is posted. Outliers will be communicated to staff involved in the episode of care and monthly to the CPB. Upon achieving 90% compliance for two consecutive quarters, the monitoring and reporting to the CPB will occur quarterly to ensure sustainment.

Recommendation 22. 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: September 30, 2016

Facility response: Inpatient and Outpatient staff were re-educated on documentation of Advance Directive screening criteria beginning on April 25, 2016 and completed by May 31, 2016 to account for staff on leave. The Inpatient Social Worker will perform a monthly review of 20 random admission records to validate the most recent advance directive discussion/status is posted. Outliers will be communicated to staff involved in the episode of care and monthly to the CPB. Upon achieving 90% compliance for two consecutive quarters, the monitoring and reporting to the CPB will change to quarterly to ensure sustainment.

Recommendation 23. 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: September 30, 2016

Facility response: A new process will be developed to ensure new Mental Health staff is assigned the appropriate TMS module. Suicide Prevention Coordinator (SPC) will run monthly TMS reports to identify those Clinicians who are deficient. Providers that are deficient and their supervisors will be notified. The TMS training compliance report will be presented quarterly to the Mental Health (MH) leadership committee. Implementation of the new process will begin June 1, 2016.

Recommendation 24. We recommended that clinicians include assessment of available lethal means and how to keep the environment safe in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: During the week of the OIG visit (March 7–11, 2016), the Suicide Prevention Coordinator (SPC) worked with a Clinical Application Coordinator (CAC) to update the "Crisis Management Plan" template in CPRS to include documentation of keeping the environment safe. Random monthly audits will be conducted to verify compliance and sustainment with results presented monthly to the MH Executive team.

Recommendation 25. We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: During the week of the OIG visit, March 7–11, 2016, the SPC worked with a CAC and updated the "Crisis Management Plan" to capture documentation the

patient received a copy of his/her safety plan. Random monthly audits will be conducted to verify compliance and sustainment with results presented monthly to the MH Executive team.

Recommendation 26. We recommended that facility managers ensure the Domiciliary Care for Homeless Veterans Program is clean and monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Chief of Domiciliary Care will update the room inspection checklist for staff to document the condition of resident's room and include benefits of having a clean room during the patient's treatment/therapy session. Documentation of discussion will be captured in the electronic medical record. The facility EMS Contracting Officer Representative (COR) will notify the contractor of frequency of cleaning the common areas and stairwells by May 2, 2016 and conduct monthly inspections to verify compliance.

Recommendation 27. We recommended that the facility repair or replace identified items in the Domiciliary Care for Homeless Veterans Program.

Concur

Target date for completion: June 15, 2016

Facility response: Work orders for repairs or replacement of identified items were electronically submitted on March 15, 2016 by the Patient Support Assistant (PSA). The Chief of the Domiciliary will monitor identified items weekly until resolved and report to the Lease COR unresolved items for escalation. Reporting on identified items closed/repaired will be reported to the Environment of Care Board monthly.

Recommendation 28. We recommended that the facility correct the deficiencies identified in the Domiciliary Care for Homeless Veterans Program and that documentation reflects correction.

Concur

Target date for completion: September 30, 2016

Facility response: The Chief of Domiciliary will develop a tracking system to capture work orders placed and record resolution. Work orders without resolution will be communicated to the Lease Contracting Officer for escalation. The new tracking system will be implemented by May 15, 2016 with monthly monitoring of close out of work orders. Monthly reports will be submitted to the EOC Board.

Recommendation 29. We recommended that facility managers ensure the Domiciliary Care for Homeless Veterans Program has closed circuit television monitors with recording capability in public areas and does not have monitors installed in treatment areas.

Concur

Target date for completion: October 1, 2016

Facility response: The areas identified as requiring closed circuit monitoring are public areas not under the facilities domain. The facility has a new location for the Domiciliary that is being constructed which will provide closed circuit monitoring in public areas with recording capability. The monitors will not be in any treatment area. The new facility is on target to open for resident use on October 1, 2016.

Recommendation 30. We recommended that facility managers ensure exit signs on Domiciliary Care for Homeless Veterans Program resident floors are visible.

Concur

Target date for completion: May 30, 2016

Facility response: The facility will secure a temporary exit sign for installation at the Domiciliary that will be visible to Residents. The sign will be ordered by May 15, 2016 and installed by May 30, 2016.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Laura Snow, LCSW, MHCL, Team Leader Stephanie Hensel, RN,JD Sherrian Pater, RN James Seitz, RN, MBA Larry Selzler, MSPT Laura Tovar, LSCSW Gregg Hirstein, Special Agent in Charge, Office of Investigations
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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.