Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00107-256

Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia

April 8, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
ADSM	active duty service member
CAP	Combined Assessment Program
CS	controlled substance
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Hunter Holmes McGuire 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
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 February 1, 2016.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following activity:

- Computed Tomography Radiation Monitoring

The facility's reported accomplishment was receiving a Certificate of Recognition from Dr. Shulkin, the VA Under Secretary for Health, for its polytrauma programs, which have served and treated veterans and active duty service members for the past 10 years.

Recommendations: We made recommendations in the following seven activities and follow-up review area:

Quality, Safety, and Value: Ensure completion of at least 75 percent of all utilization management reviews.

Environment of Care: Ensure patient care area floors and operating rooms are clean. Promptly remove outdated commercial supplies and expired medications from patient care areas. Repair or replace damaged furniture in the operating rooms.

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 policy to include verification of all finished compounded sterile products by a pharmacist. Perform and document cleaning of storage shelving and bins in all compounding areas.

Coordination of Care: Provide discharge instructions to patients and/or caregivers.

Advance Directives: Implement a plan for transition to the allowed note titles. Screen inpatients to determine whether they have advance directives, and document the screening. Use the required advance directive note titles.

Suicide Prevention Program: Ensure new clinical employees complete suicide risk management training within 90 days of being hired.

Mammography Services: Include all required elements in the mammography services policy.

Follow-Up on Medication Management – Controlled Substances Inspection Program: Inspect all required non-pharmacy areas with controlled substances. Consistently conduct weekly inventories of automated dispensing machines.

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 29–35, 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 and follow-up review area from the previous CAP review:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Mammography Services
- Follow-Up on Medication Management– CS Inspection Program

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

The review covered facility operations for FY 2015 and FY 2016 through February 5, 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 Hunter Holmes McGuire VA Medical Center, Richmond, Virginia,* Report No. 13-00899-261, August 5, 2013). We made repeat recommendations in Medication Management – CS Inspection Program and EOC.

During this review, we presented crime awareness briefings for 114 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 705 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

Polytrauma Programs

On December 16, 2015, Dr. Shulkin, the VA Under Secretary for Health, presented the facility's polytrauma programs with a Certificate of Recognition for 10 years of service to veterans and ADSMs. The facility's polytrauma programs have treated thousands of veterans and ADSMs with complex needs post-deployment. The polytrauma programs are comprised of the following:

Polytrauma Rehabilitation Center: Since 2010, this program has served 378 ADSMs and veterans with acute rehabilitation needs from polytraumatic injuries (traumatic brain injury, multiple fractures, complex blast injuries) in an inpatient setting.

Polytrauma Transitional Rehabilitation Program and *Servicemember Transitional Advanced Rehabilitation Program:* The Polytrauma Transitional Rehabilitation Program is a residential program that treats ADSMs and veterans with significant cognitive or physical impairments which preclude return to home or community. This program uses an interdisciplinary team approach to enhancing a person's function in order to live independently. The Servicemember Transitional Advanced Rehabilitation program treats ADSMs and veterans with cognitive or functional deficits that limit the ability to work. This program is the only residential program in the VA that uses a supported employment approach that enables a person to return to work or active duty. Since 2010, the facility has treated 410 patients in these two programs.

Polytrauma Network Site Clinic: This program diagnoses and treats ADSMs and veterans with traumatic brain injury and complications. Since 2010, the program has served 5,125 patients and diagnosed 767 patients with brain injury.

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 area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	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 the timeframe January 1, 2015, through December 31, 2015, the facility completed only 67.5 percent of all required reviews.	**1.** We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews 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.		
	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 community living center; the Emergency Department; the medical intensive care/cardiac care, MH inpatient, and spinal cord injury units; a medical inpatient and a surgical inpatient unit; primary care; specialty care; the dental clinics; and the OR. Additionally, we reviewed relevant documents and 18 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Floors in all nine patient care areas were dirty. This was a repeat finding from the previous CAP review.	**2.** We recommended that facility managers ensure floors in patient care areas are clean and monitor compliance.
X	The facility met infection prevention requirements.	• Three of nine patient care areas contained outdated commercial supplies.	**3.** We recommended that employees promptly remove outdated commercial supplies from patient care areas and that facility managers monitor compliance.
X	The facility met medication safety and security requirements.	• Four of eight patient care areas had expired medications.	**4.** We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance.
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
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.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Joint Commission standards reviewed, which require areas used by patients to be clean and furnishings to be in good repair. • In the OR suite, the three ORs inspected were dirty. • Three chairs—one in each of the three ORs inspected—were not in good repair.	**5.** We recommended that facility managers ensure operating rooms are clean and monitor compliance. **6.** We recommended that the facility repair or replace damaged furniture in the operating rooms.

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 two areas 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.	**7.** 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 CS		
X	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.	• The facility's CSP safety policy did not include verification of all finished CSPs by a pharmacist.	**8.** We recommended that the facility revise the compounded sterile products safety policy to include verification of all finished compounded sterile products by a pharmacist.
	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.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• Although there was documentation of cleaning at required intervals, in one of the two compounding areas, we observed dusty storage shelving and dusty bins that contained debris.	**9.** We recommended that facility managers ensure employees perform and document cleaning of storage shelving and bins in all compounding areas and monitor compliance.
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The 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.		
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.	• Fifteen of the applicable 31 EHRs (48 percent) did not contain documentation that clinicians provided discharge instructions to patients and/or caregivers.	**10.** We recommended that clinicians provide discharge instructions to patients and/or caregivers.
	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 14 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. 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		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
	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 32 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
X	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles	• Non-allowed note titles were in common use, and there was no plan for transition to the allowed note titles.	**11.** We recommended that the facility implement a plan for transition to the allowed note titles.
X	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.	• Four of the 32 EHRs (13 percent) did not contain documentation that employees screened inpatients to determine whether they had ADs.	**12.** We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.
	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.	• Employees did not use the required note titles in any of the three AD discussion notes.	**13.** We recommended that employees use the required advance directive note titles 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	• Seven of the 10 applicable training records indicated that clinicians did not complete suicide risk management training within 90 days of being hired.	**14.** We recommended that the facility ensure new clinical employees complete suicide risk management training within 90 days of being hired and that facility managers monitor compliance.
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	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.		
	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.		

Mammography Services

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

We reviewed relevant documents and the EHRs of 30 women veterans 50–74 years of age who had a screening mammogram July 1, 2014, to June 30, 2015, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a policy addressing mammography services that included required elements.	• The facility's mammography services policy did not include all required elements.	**15.** We recommended that the facility ensure the mammography services policy includes all required elements.
NA	If the facility outsourced mammograms, it defined requirements for turnaround time.		
	Clinicians linked mammogram results to the radiology order in the EHR.		
	Mammogram result reports included required elements.		
	Interpreting clinicians reported mammogram results using American College of Radiology codes.		
	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.		
NA	Clinicians communicated "suspicious" or "highly suggestive of malignancy" results and recommended actions to the patient within 5 business days of the procedure and documented this in the EHR.		
	Clinicians communicated incomplete or "probably benign" results to the patient within 14 days from availability of the results and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
NA	The facility ensured communication of "suspicious" or "highly suggestive of malignancy" results and the recommended course of action to the ordering clinician or responsible designee within 3 business days of the procedure date.		
	The facility designated a full-time Women Veterans Program Manager who was a health care professional with a minimal allotment of clinical time to maintain clinical competency.		
	The facility had established effective mammography oversight processes.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity With Previous CAP Recommendations

Follow-Up on Medication Management – CS Inspection Program

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with CS inspections.[i]

CS Inspections. During our previous CAP review, we identified that required inspections of non-pharmacy areas with CS and weekly inventories of automated dispensing machines were not consistently completed. The facility provided four CS inspection quarterly trend reports for FY 2015, which showed inconsistent completion of CS inspections of non-pharmacy areas. Additionally, the facility provided weekly CS inspection documentation for June through October 2015, which showed CS inspectors did not consistently complete inventories of automated dispensing machines in 12 areas.

Recommendations

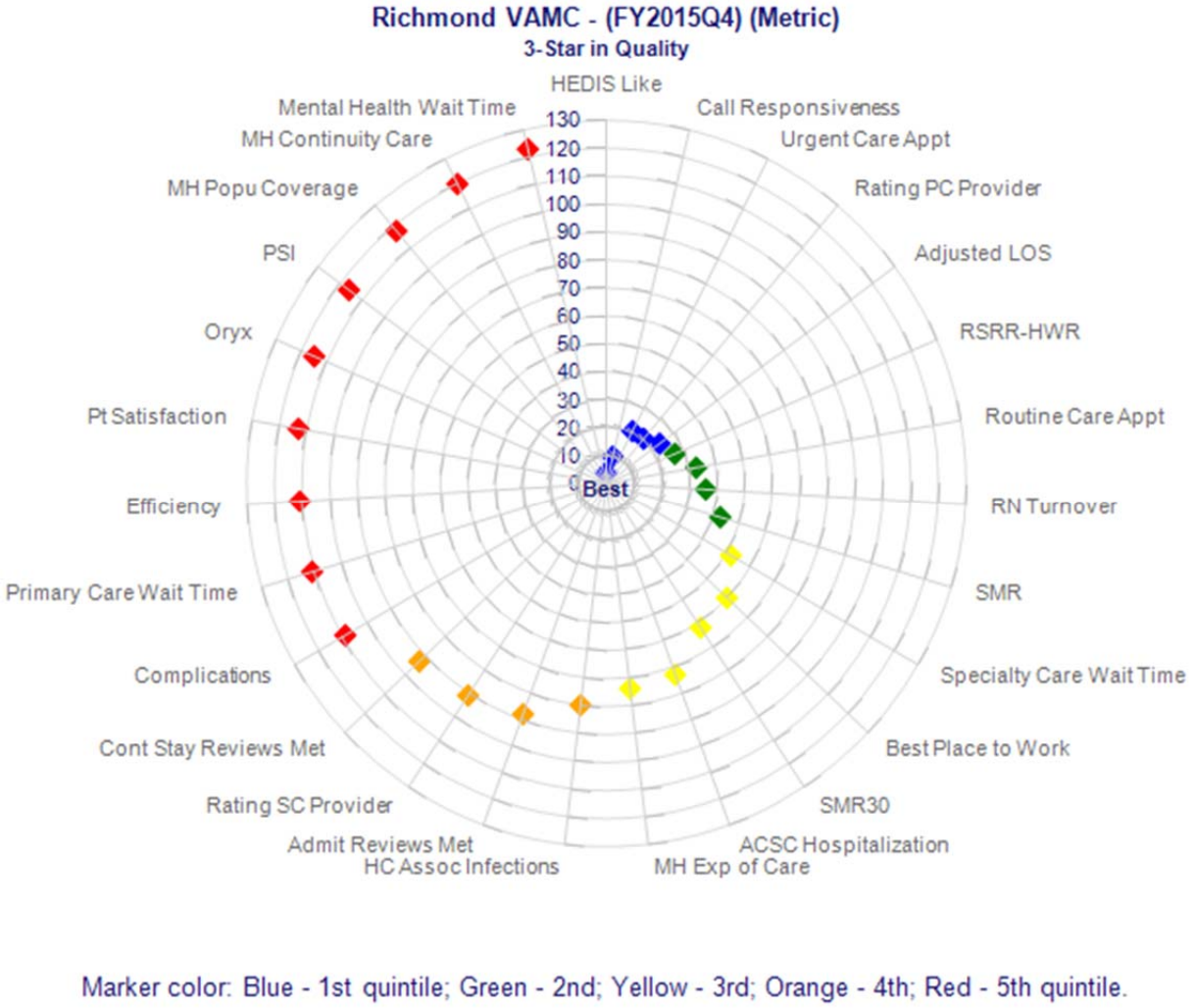
16. We recommended that the Controlled Substances Coordinator ensure all required non-pharmacy areas with controlled substances are inspected and monitor compliance.

17. We recommended that the facility strengthen processes to ensure weekly inventories of automated dispensing machines are consistently conducted and that facility managers monitor compliance.

Facility Profile (Richmond/652) FY 2016 through February 2016[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$208.2
Number of:	
• **Unique Patients**	43,030
• **Outpatient Visits**	232,217
• **Unique Employees**[2]	2,822
Type and Number of Operating Beds (as of January 2016):	
• **Hospital**	283
• **Community Living Center**	98
• **Domiciliary**	16
Average Daily Census (as of January 2016):	
• **Hospital**	180
• **Community Living Center**	44
• **Domiciliary**	9
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Fredericksburg/652GA Charlottesville/652GE Emporia/652GF
Veterans Integrated Service Network Number	6

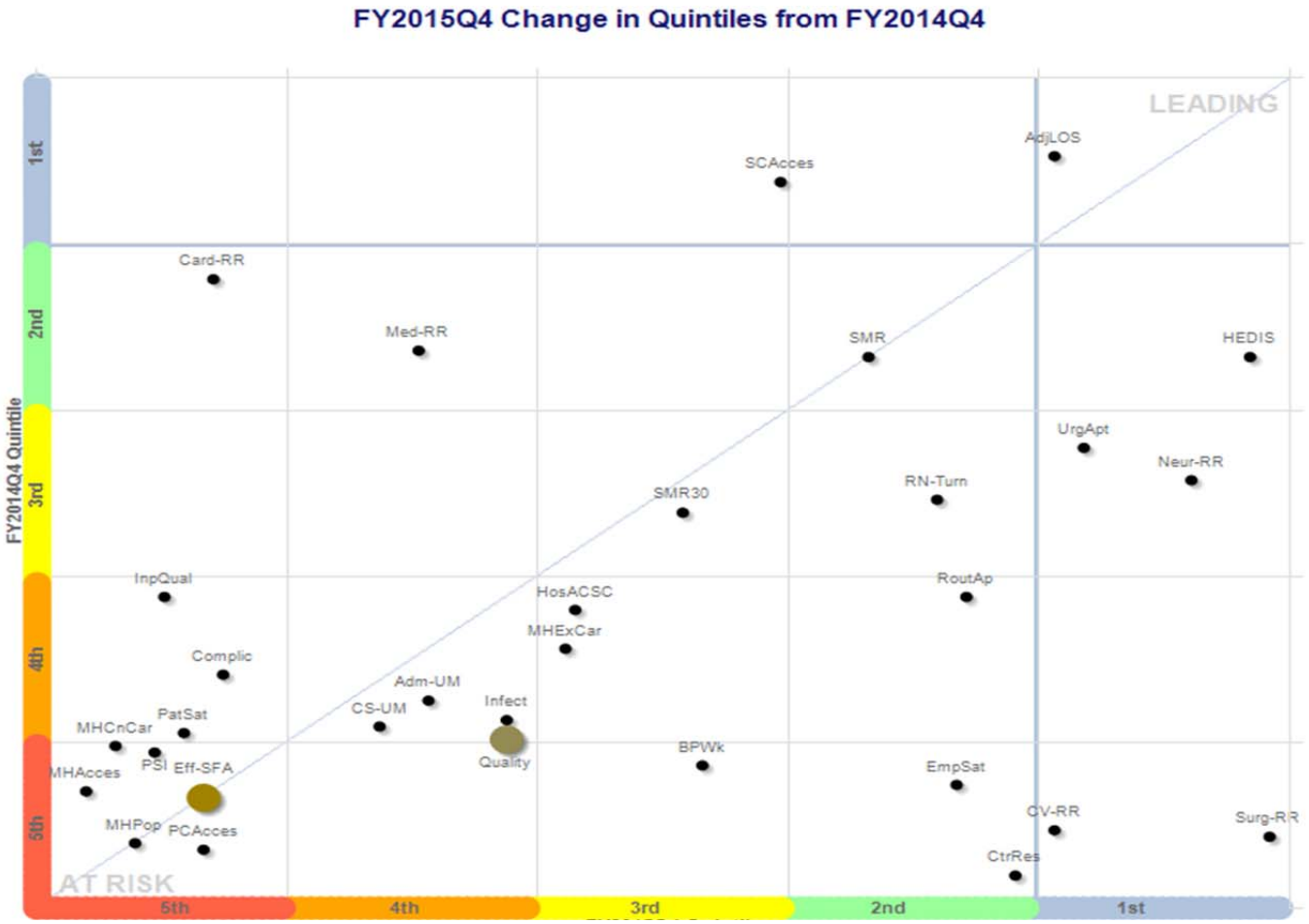
[1] All data is for FY 2016 through February 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 29, 2016

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

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

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

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Richmond VA Medical Center (VAMC), Richmond, VA and concur with the facility's recommendations.

2. If you have further questions, please contact John Brandecker, Director, Richmond VAMC, at (804) 675-5500.

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 21, 2016

From: Director, Hunter Holmes McGuire VA Medical Center (652/00)

Subject: **CAP Review of the Hunter Holmes McGuire VA Medical Center, Richmond, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. I would like to express my appreciation to the Office of Inspector General Survey Team for their professional and comprehensive review conducted on February 1–5, 2016.

2. I have reviewed the draft report for Hunter Holmes McGuire VA Medical Center, Richmond, VA and concur with the findings and recommendations.

3. If you have any questions regarding the response to the recommendations, feel free to call me at (804) 675-5500.

John A. Brandecker
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Richmond VAMC has hired 2 additional UM staff reviewers. They are reviewing a minimal of 75% of all UM reviews. Data will be reported monthly to the Utilization Management Committee.

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

Concur

Target date for completion: July 15, 2016

Facility response: Identified rooms were cleaned immediately and cleanliness was verified by performing ATP testing. EMS staff will be educated on the SOP for cleaning of the environment. EMS will verify cleanliness of rooms by performing ATP testing daily on a sample of rooms cleaned. Compliance data will be collected and reported monthly to the Environment of Care Committee.

Recommendation 3. We recommended that employees promptly remove outdated commercial supplies from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Clinical staff will be educated on the responsibility for checking expiration date on supplies prior to use. Staff in patient care areas will inspect supplies to ensure that outdated items are removed. All supply rooms in patient care areas of the organization will be monitored monthly by department staff. Compliance data will be collected and reported monthly to the Environment of Care Committee.

Recommendation 4. We recommended that employees promptly remove expired medications from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Clinical Service Chiefs will review the policy on expiration dates for medication. Staff in patient care areas will inspect medications to ensure that expired medications are removed. All medications in patient care areas will be monitored monthly for expiration dates. Compliance data will be collected and reported monthly to the Environment of Care Committee.

Recommendation 5. We recommended that facility managers ensure operating rooms are clean and monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Unclean rooms were re-cleaned and cleanliness validated by ATP testing prior to use. EMS staff will be educated on the SOP for cleaning of operating rooms. Rooms will be cleaned and cleanliness validated by ATP testing on all operating rooms at least once daily between cases and at the end of the day after the last case. Compliance data will be collected and reported monthly to the Environment of Care Committee.

Recommendation 6. We recommended that the facility repair or replace damaged furniture in the operating rooms.

Concur

Target date for completion: July 15, 2016

Facility response: All damaged furniture has been repaired or replaced. EOC rounds and internal traces will assess integrity of furniture in the Operating Rooms and report data to the Environment of Care Committee. Work orders or purchase orders will be placed by Engineering Service to repair or replace furniture as appropriate.

Recommendation 7. 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: July 15, 2016

Facility response: Pharmacy Service revised the SOP IV-12 during the site visit 2/3/16 to include gloved fingertip sampling at the required intervals. Staff will receive training on the SOP. Compliance data on gloved fingertip sampling will be reported to Pharmacy and Therapeutics Committee.

Recommendation 8. We recommended that the facility revise the compounded sterile products safety policy to include verification of all finished compounded sterile products by a pharmacist.

Concur

Target date for completion: July 15, 2016

Facility response: Pharmacy Service revised the SOP IV-16 during the site visit 2/3/16 to include verification of all finished compounded sterile products by a pharmacist. Staff will receive training on the SOP. Verification data will be monitored and reported monthly to the Pharmacy and Therapeutics Committee.

Recommendation 9. We recommended that facility managers ensure employees perform and document cleaning of storage shelving and bins in all compounding areas and monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Bins in Chemo Prep room cleaned during site visit 2/3/16. Staff will be educated on proper cleaning of the bins. The bins will be cleaned in all compounding areas weekly by pharmacy staff. Compliance data will be reported monthly to the Pharmacy and Therapeutics Committee.

Recommendation 10. We recommended that clinicians provide discharge instructions to patients and/or caregivers.

Concur

Target date for completion: July 15, 2016

Facility response: Edit made to Nursing Discharge Summary template to include mandatory documentation stating “A copy of discharge instructions was given to (options available)”. Compliance will be monitored through retrospective chart review. Data will be reported monthly to the Nurse Quality Council.

Recommendation 11. We recommended that the facility implement a plan for transition to the allowed note titles.

Concur

Target date for completion: July 15, 2016

Facility response: MCM 11-23 Advance Care Planning and Management of Advance Directives was published January 21, 2016 and mandates the required note titles to be used for Advance Care Planning. IT removed old note titles and only approved note titles remain in CPRS. Compliance will be monitored through retrospective chart review. Data will be reported monthly to the Medical Records Committee.

Recommendation 12. We recommended that employees screen inpatients to determine whether they have advance directives and document the screening and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: The Advanced Directive screening question was added to the Nursing Admission Assessment template in January 2016. Compliance will be monitored through retrospective chart review. Data will be reported monthly to the Medical Records Committee.

Recommendation 13. We recommended that employees use the required advance directive note titles and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: Current MCM 11-23, Advance Care Planning and Management of Advance Directives mandate that the Advance Directive Discussion note title be used when an advance directive discussion has been held. Compliance will be monitored through retrospective chart review. Data will be reported monthly to the Medical Records Committee.

Recommendation 14. We recommended that the facility ensure new clinical employees complete suicide risk management training 90 days of being hired and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: All new clinical employees will be required to complete suicide risk management training within 90 days of being hired. Clinical Service Chiefs will ensure that this has been assigned to their staff. Monitor 100 % of new clinical employees for completion and documentation in TMS of suicide risk management training within 90 days of being hired. Data will be collected and reported monthly to the Quality Executive Board.

Recommendation 15. We recommended that the facility ensure the mammography services policy includes all required elements.

Concur

Target date for completion: July 15, 2016

Facility response: The policy, MCM-171-16, The Delivery of Women Veterans Health Care has been revised to include all required elements. It is pending publication.

Recommendation 16. We recommended that the Controlled Substances Coordinator ensure all required non-pharmacy areas with controlled substances are inspected and monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: CSC will ensure that all required non-pharmacy areas with controlled substances are inspected. Duties have been delegated to two new CSCs and education provided. Compliance will be monitored. Data will be collected and reported monthly to Quality Executive Board.

Recommendation 17. We recommended that the facility strengthen processes to ensure weekly inventories of automated dispensing machines are consistently conducted and that facility managers monitor compliance.

Concur

Target date for completion: July 15, 2016

Facility response: CSC will ensure that all automated dispensing machines are inspected weekly. Duties have been delegated to two new CSCs and education provided. Compliance will be monitored. Data will be collected and reported monthly to the Quality Executive Board.

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 included:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

[i] The references used for this topic were:

- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.