



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 16-00112-267

**Combined Assessment Program
Review of the
James H. Quillen VA Medical Center
Mountain Home, Tennessee**

April 21, 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 | James H. Quillen 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 |

Table of Contents

| | Page |
|--|------|
| Executive Summary | i |
| Objectives and Scope | 1 |
| Objectives | 1 |
| Scope..... | 1 |
| Reported Accomplishments | 2 |
| Results and Recommendations | 4 |
| QSV | 4 |
| EOC | 7 |
| Medication Management..... | 10 |
| Coordination of Care..... | 13 |
| CT Radiation Monitoring | 16 |
| ADs | 18 |
| Suicide Prevention Program | 19 |
| MH RRTP | 21 |
| Appendixes | |
| A. Facility Profile | 23 |
| B. Strategic Analytics for Improvement and Learning (SAIL) | 24 |
| C. Veterans Integrated Service Network Director Comments | 27 |
| D. Acting Facility Director Comments | 28 |
| E. Office of Inspector General Contact and Staff Acknowledgments | 30 |
| F. Report Distribution | 31 |
| G. Endnotes..... | 32 |

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 14, 2016.

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

- Quality, Safety, and Value
- Environment of Care
- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring
- Advance Directives

The facility's reported accomplishments were its Wound Care Program and culture of patient safety.

Recommendations: We made recommendations in the following two activities:

Suicide Prevention Program: Ensure the Suicide Prevention Coordinator consistently provides at least five community outreach activities every month.

Mental Health Residential Rehabilitation Treatment Program: Ensure that Domiciliary Care for Homeless Veterans Program employees consistently perform and document weekly inspections of a minimum of 10 percent of resident rooms for contraband and that Mental Health Residential Rehabilitation Treatment Program employees consistently perform and document daily resident room inspections for unsecured medications.

Comments

The 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 27–29, 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 14, 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 James H. Quillen VA Medical Center, Mountain Home, Tennessee*, Report No. 13-02643-20, November 22, 2013).

During this review, we presented crime awareness briefings for 73 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 576 responses. We shared summarized results with facility managers.

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

Reported Accomplishments

Excellence in Wound Care Program

The facility has a nationally recognized Wound Care Program that provides lymphedema¹ management and wound and ostomy care for patients in acute care, primary care, the community living center, and the outpatient wound clinic and through the Tele-Wound Program.² The facility is one of only five nationally recognized sites approved to perform Store-and-Forward Telehealth³ for wound care. Additionally, the facility participates in cutting-edge pressure ulcer research and is a two-time recipient of the VHA Innovation Award for its aggressive approach to decrease the incidence of hospital-acquired pressure ulcers. The facility's hospital-acquired pressure ulcer rate decreased from 3.2 percent in 2011 to 0.25 percent in FY 2015.

Performance Excellence and Patient Safety Culture

The facility continues its journey to engrain performance excellence and a culture of patient safety as the foundation of all care provided. This has been accomplished through employee training and programs such as "The Good Catch" program, which

¹ Lymphedema is an abnormal collection of high-protein fluid just beneath the skin. This swelling, or edema, occurs most commonly in the arm or leg.

² In the Tele-Wound Program, specialists in wound care use EHRs and images sent electronically for patients in nursing homes, outpatient clinics, and home care.

³ Store-and-Forward Telehealth is the acquisition and storage of clinical information (data, images, sound, video) that is then forwarded to (or retrieved by) another site for clinical evaluation. <http://www.telehealth.va.gov/sft/> Accessed March 23, 2016.

encourages and positively acknowledges reporting close calls and near miss incidents that could have had a negative patient outcome. This journey of excellence received recognition through the Robert W. Carey Performance Excellence Trophy Award and State of Tennessee Baldrige award. In addition, the facility's Patient Safety Program has received a gold award from the VA National Center for Patient Safety every year since 2010 for a strong root cause analysis process.

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. 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 |
|----|--|----------|-----------------|
| | 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. <ul style="list-style-type: none"> • The committee routinely reviewed aggregated data. | | |
| | Credentialing and privileging processes met selected requirements: <ul style="list-style-type: none"> • 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 |
|-----------|--|-----------------|------------------------|
| | <p>Protected peer reviews met selected requirements:</p> <ul style="list-style-type: none"> • 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. | | |
| | <p>Utilization management met selected requirements:</p> <ul style="list-style-type: none"> • 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. | | |
| | <p>Patient safety met selected requirements:</p> <ul style="list-style-type: none"> • The Patient Safety Manager entered all reported patient incidents into the WEBSPOOT 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 medical/surgical/telemetry, intensive care, progressive care, post-anesthesia care, and locked MH units; two community living center units; the Emergency Department; the Physical Medicine and Rehabilitation Service; the OR; and the dental and cardiology clinics. Additionally, we reviewed relevant documents and 21 employee-training records, and we conversed with key employees and managers. 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 for General EOC | Findings | Recommendations |
|----|---|----------|-----------------|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics. | | |
| | The facility conducted an infection prevention risk assessment. | | |
| | Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data. | | |
| | The facility had established a process for cleaning equipment between patients. | | |
| | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | | |
| | The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements. | | |
| | The facility met fire safety requirements. | | |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|----|--|----------|-----------------|
| | The facility met environmental safety requirements. | | |
| | The facility met infection prevention requirements. | | |
| | The facility met medication safety and security requirements. | | |
| | The facility met privacy requirements. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | Areas Reviewed for Dental Clinic | | |
| | Dental clinic employees completed bloodborne pathogens training within the past 12 months. | | |
| | Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets. | | |
| | Designated dental clinic employees received laser safety training in accordance with local policy. | | |
| | The facility tested dental water lines in accordance with local policy. | | |
| | The facility met environmental safety and infection prevention requirements in the dental clinic. | | |
| | The facility met laser safety requirements in the dental clinic. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

| NM | Areas Reviewed for the OR | Findings | Recommendations |
|----|--|----------|-----------------|
| | The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen. | | |
| | The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination. | | |
| | OR housekeepers received training on OR cleaning/disinfection in accordance with local policy. | | |
| | The facility monitored OR temperature, humidity, and positive pressure. | | |
| | The facility met fire safety requirements in the OR. | | |
| | The facility met environmental safety requirements in the OR. | | |
| | The facility met infection prevention requirements in the OR. | | |
| | The facility met medication safety and security requirements in the OR. | | |
| | The facility met laser safety requirements in the OR. | | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.^c

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees (3 pharmacists and 7 technicians). Additionally, we inspected the area where sterile products are compounded. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|----------|-----------------|
| | <p>The facility had a policy on preparation of CSPs that included required components:</p> <ul style="list-style-type: none"> • 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 | | |
| | <p>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.</p> | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|--|----------|-----------------|
| | <p>If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility:</p> <ul style="list-style-type: none"> • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances | | |
| | <p>The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.</p> | | |
| | <p>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.</p> | | |
| | <p>The facility had a process to track and report CSP medication errors, including near misses.</p> | | |
| | <p>The facility met design and environmental safety controls in compounding areas.</p> | | |
| | <p>The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.</p> | | |
| | <p>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.</p> | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|---|----------|-----------------|
| | If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas. | | |
| | Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure. | | |
| | An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing. | | |
| | The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies. | | |
| | During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months. | | |
| | <p>Prepared CSPs had labels with required information prior to delivery to the patient care areas:</p> <ul style="list-style-type: none"> • 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 34 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|----------|-----------------|
| | The facility had a policy that addressed patient discharge and scheduling discharges early in the day. | | |
| | The facility had a policy that addressed temporary bed locations, and it included: <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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 |
|----|--|----------|-----------------|
| | <ul style="list-style-type: none"> 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. | | |
| | <p>Nurses completed admission assessments within 1 day of the patient's admission.</p> | | |
| | <p>When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer.</p> <ul style="list-style-type: none"> When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. Receiving physicians documented transfers. | | |
| | <p>When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.</p> | | |
| | <p>Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels.</p> <ul style="list-style-type: none"> 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 we conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|----------|-----------------|
| | The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program. | | |
| | The facility had a CT/imaging/radiation safety policy or procedure that included: <ul style="list-style-type: none"> • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|----|--|----------|-----------------|
| | A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months. | | |
| | A medical physicist tested a sample of CT protocols at least annually. | | |
| | A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service. | | |
| | If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information. | | |
| | CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification. | | |
| | There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring. | | |
| | If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.^f

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NM | Areas Reviewed | Findings | Recommendations |
|----|---|----------|-----------------|
| | The facility had an AD policy that addressed: <ul style="list-style-type: none"> • AD notification, screening, and discussions • Proper use of AD note titles | | |
| | Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening. | | |
| | When patients provided copies of their current ADs, employees had scanned them into the EHR. <ul style="list-style-type: none"> • Employees correctly posted patients' AD status. | | |
| | Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. <ul style="list-style-type: none"> • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles. | | |
| | The facility met any additional elements required by VHA or local policy. | | |

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility’s MH providers consistently complied with selected suicide prevention program requirements.⁹

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 | Recommendation |
|----|---|---|--|
| | 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. | | |
| | The facility provided training within required timeframes: <ul style="list-style-type: none"> • Suicide prevention training to new employees • Suicide risk management training to new clinical employees | | |
| X | The facility provided at least five suicide prevention outreach activities to community organizations each month. | <ul style="list-style-type: none"> • In the 3 months prior to the site visit, the Suicide Prevention Coordinator provided evidence of only two outreach activities for 1 month and four outreach activities for another month. | 1. We recommended that the Suicide Prevention Coordinator consistently provide at least five community outreach activities every month and that facility managers monitor compliance. |
| | The facility completed required reports and reviews regarding patients who attempted or completed suicide. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendation |
|----|---|----------|----------------|
| | Clinicians assessed patients for suicide risk at the time of admission. | | |
| | Clinicians appropriately placed Patient Record Flags: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 and the general domiciliary RRTP complied with selected EOC requirements.^h

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program female and male units and the general domiciliary RRTP units P and PG, and conversed with key 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 | Recommendation |
|----|---|--|--|
| | The residential environment was clean and in good repair. | | |
| | Appropriate fire extinguishers were available near grease producing cooking devices. | | |
| | There were policies/procedures that addressed safe medication management and contraband detection. | | |
| | 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. | | |
| X | MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications. | <ul style="list-style-type: none"> • For the month of February 2016, Domiciliary Care for Homeless Veterans Program employees did not document weekly inspections of a minimum of 10 percent of resident rooms for contraband. • For the 13-day period February 8–20, 2016, MH RRTP employees did not consistently document daily resident room inspections for unsecured medications. | <p>2. We recommended that Domiciliary Care for Homeless Veterans Program employees consistently perform and document weekly inspections of a minimum of 10 percent of resident rooms for contraband and that program managers monitor compliance.</p> <p>3. We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently perform and document daily resident room inspections for unsecured medications and that program managers monitor compliance.</p> |

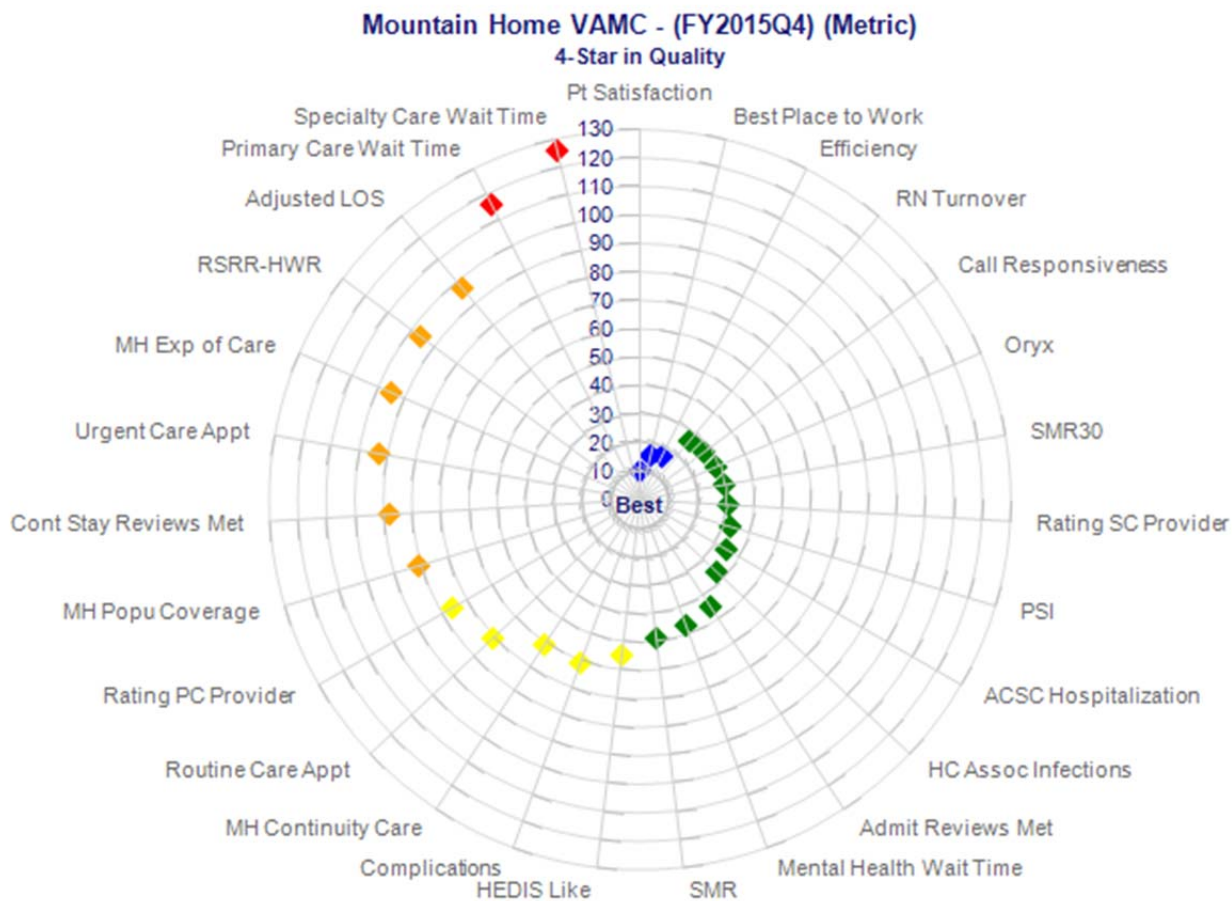
| NM | Areas Reviewed (continued) | Findings | Recommendation |
|----|--|----------|----------------|
| | The MH RRTP had written agreements in place acknowledging resident responsibility for medication security. | | |
| | MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed. | | |
| | 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. | | |
| | 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. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

| Facility Profile (Mountain Home/621) FY 2016 through February 2016 | |
|---|--|
| Type of Organization | Secondary |
| Complexity Level | 1c-High complexity |
| Affiliated/Non-Affiliated | Affiliated |
| Total Medical Care Budget in Millions | \$396.7 |
| Number of: | |
| • Unique Patients | 45,301 |
| • Outpatient Visits | 281,263 |
| • Unique Employees⁴ | 2,056 |
| Type and Number of Operating Beds: | |
| • Hospital | 102 |
| • Community Living Center | 120 |
| • Domiciliary | 150 |
| Average Daily Census: | |
| • Hospital | 79 |
| • Community Living Center | 68 |
| • Domiciliary | 105 |
| Number of Community Based Outpatient Clinics⁵ | 7 |
| Location(s)/Station Number(s) | Knoxville/621BY Rogersville/621GA Norton/621GC Morristown/621GG Sevierville/621GI Bristol/621GJ LaFollette/621GK |
| Veterans Integrated Service Network Number | 9 |

⁴ Unique employees involved in direct medical care (cost center 8200).

⁵ We have omitted 621QA (Norton), 621QB (Marion), 621QC (Vansant), 621QD (Knoxville), and 621BU (Mountain Home) as no workload/encounters or services were reported.

Strategic Analytics for Improvement and Learning (SAIL)⁶

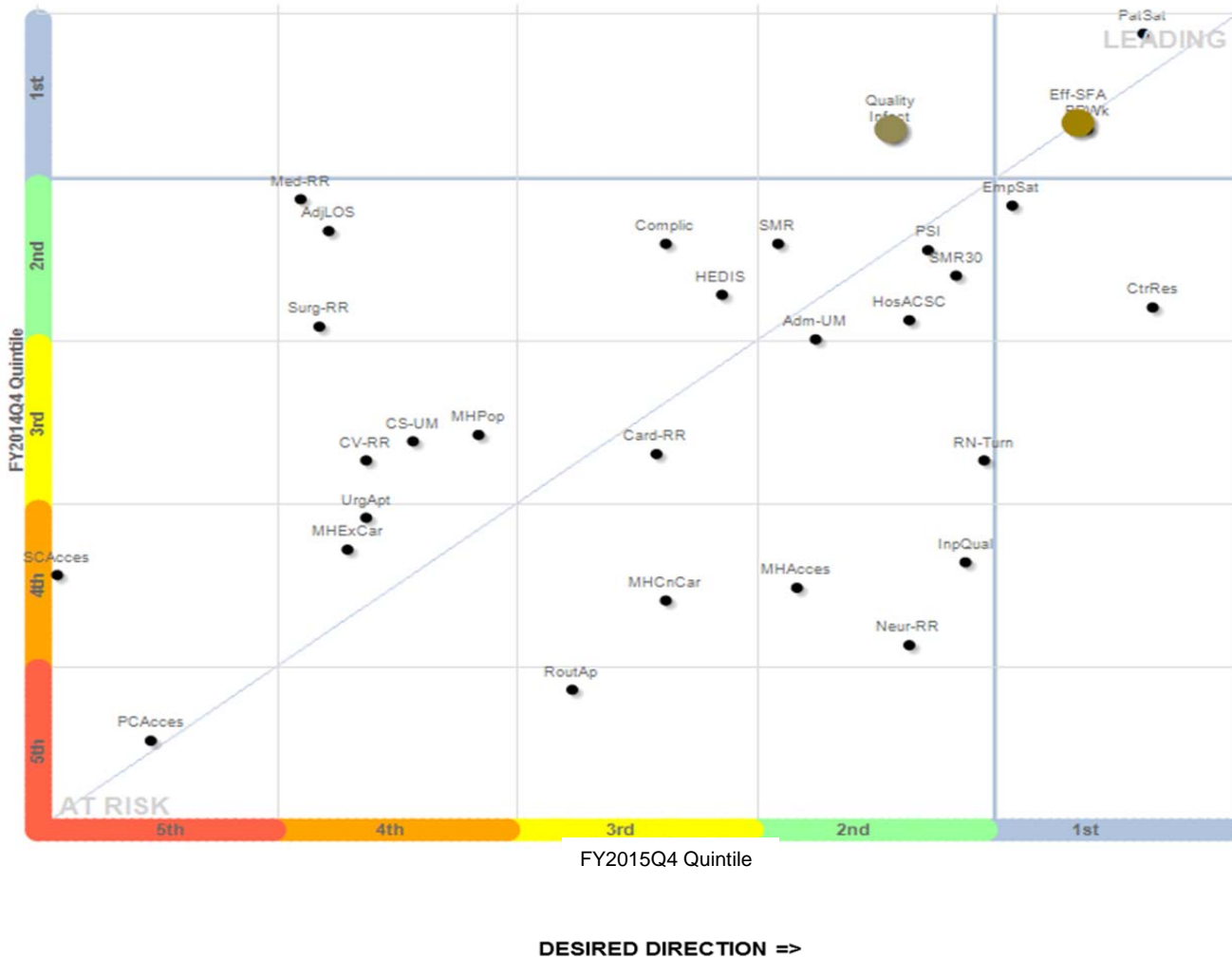


Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

⁶ Metric definitions follow the graphs.

Scatter Chart

FY2015Q4 Change in Quintiles from FY2014Q4



NOTE

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

DESIRED DIRECTION =>

DESIRED DIRECTION =>

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: April 6, 2016

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **CAP Review of the James H. Quillen VA Medical Center,
Mountain Home, TN**

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

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

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, as well as the action plan developed by the facility.
2. If you have any questions or need additional information from the Network, please do not hesitate to contact me at 615-695-2206.



John E. Patrick

Acting Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 4, 2016

From: Acting Director, James H. Quillen VA Medical Center (621/00)

Subject: **CAP Review of the James H. Quillen VA Medical Center,
Mountain Home, TN**

To: Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report.
2. Included herein is an outline of improvement actions taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes throughout our healthcare system.



Daniel Snyder, P.E., FACHE

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

Concur

Target date for completion: September 30, 2016

Facility response: The Suicide Prevention Coordinators are assigned to ensure at least five community outreach activities are completed every month with a summation to be reported to Mental Health Executive Council as a standing agenda item to ensure 100 percent compliance. These outreach activities are to be recorded and reported to the Mental Health Social Work Supervisor on a weekly basis.

Recommendation 2. We recommended that Domiciliary Care for Homeless Veterans Program employees consistently perform and document weekly inspections of a minimum of 10 percent of resident rooms for contraband and that program managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Mental Health Residential Rehabilitation Treatment Program weekly inspection sheets have been revised to include verbiage of no contraband found. The documentation of weekly contraband inspections will be monitored by Chief, Domiciliary and reported to Mental Health Executive Council as standing agenda item to ensure 100 percent compliance.

Recommendation 3. We recommended that Mental Health Residential Rehabilitation Treatment Program employees consistently perform and document daily resident room inspections for unsecured medications and that program managers monitor compliance.

Concur

Target date for completion: September 30, 2016

Facility response: The Mental Health Residential Rehabilitation Treatment Program daily room inspection sheets have been revised to require Chief/Assistant Chief Domiciliary or designated Administrator on Duty signature and daily approval to ensure documentation of unsecured medication checks. These daily monitors are required to be 100% and will be reported to Mental Health Executive Council as a standing agenda item.

Office of Inspector General Contact and Staff Acknowledgments

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

Endnotes

^a The references used for this topic were:

- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

^b The references used for this topic included:

- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

^c The references used for this topic included:

- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

^d The references used for this topic included:

- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

^e The references used for this topic included:

- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

^f The references used for this topic included:

- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

^g The references used for this topic included:

- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

^h The references used for this topic were:

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