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

**Office of Healthcare Inspections**

**Report No. 15-00619-515**

# Combined Assessment Program Review of the Robley Rex VA Medical Center Louisville, Kentucky

**September 17, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| AD | advance directive |
| CAP | Combined Assessment Program |
| CT | computed tomography |
| EAM | emergency airway management |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Robley Rex VA Medical Center |
| FY | fiscal year |
| LNET | lung nodule evaluation team |
| MH | mental health |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| QM | quality management |
| SCI | spinal cord injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 3, 2015.

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

- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring
- Surgical Complexity

The facility's reported accomplishments were the lung nodule evaluation team and the Women's Health Program.

**Recommendations:** We made recommendations in the following four activities:

*Quality Management:* Require that licensed practitioners who perform emergency airway management have the appropriate training. Ensure the Surgical Work Group meets monthly.

*Environment of Care*: Conduct fire drills in all health care occupancy buildings with the frequency required. Ensure negative pressure systems in the medicine primary care clinic are functional. Require locked mental health unit stationary panic alarm testing to include documentation of VA Police response time. Secure equipment on the locked mental health unit.

*Advance Directives*: Offer inpatients the opportunity to discuss advance directives, hold the requested discussions, and document the discussions.

*Emergency Airway Management*: Ensure that initial clinician emergency airway management competency assessment includes all required elements. Revise the local out of operating room emergency airway management policy to include requirements for successful demonstration of procedural skills. Document the review of provider-specific emergency airway management data in Cardiopulmonary Review Committee meeting minutes.

## 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 26–31, for the full text of the Directors' comments.) We consider recommendation 6 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

# Objectives and Scope

## Objectives

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

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

## Scope

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

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM

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 2014 and FY 2015 through August 3, 2015, 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 Robley Rex VA Medical Center, Louisville, Kentucky,* Report No. 13-00433-199, May 20, 2013).

During this review, we presented crime awareness briefings for 255 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 311 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

## The LNET

The LNET is a multidisciplinary group of health care providers who evaluate and manage patients with lung nodules (a small round or oval-shaped growth in the lung). Once a nodule is identified, an electronic consult notifies the LNET. The LNET then reviews the consults and determines the appropriate management disposition—surveillance, diagnostics, or therapy. On average, 189 LNET consults are entered each month. This has decreased the time from initial imaging to a definitive management plan by a specialist from 49.1 days to only 3.7 days.

## Women's Health Program

The facility's Women's Health Program has expanded and flourished in the last year. The facility offered more than 3,000 female veterans reassignment to designated women's health providers, and to accommodate the increased demand, it added two designated women's health providers and a community provider for mammograms. In addition, the facility offers comprehensive evening women's primary care and gynecology services. A Women's Health Nurse Navigator coordinates maternity patients, mammography, Pap tracking, and non-VA referrals. In February, the facility held a Go Red Event to provide education on women's heart health and established a women-only yoga class. On April 11, 2015, in collaboration with the State Department of Veterans Affairs, the facility held the first ever state conference for women veterans in addition to the annual women's fair held for the last 4 years.

# Results and Recommendations

## QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 22 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director.<br>• The committee routinely reviewed aggregated data.<br>• QM, patient safety, and systems redesign appeared to be integrated. | | |
| | Peer reviewed deaths met selected requirements:<br>• Peers completed reviews within specified timeframes.<br>• The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings.<br>• Involved providers were invited to provide input prior to the final Peer Review Committee determination. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| X | Credentialing and privileging processes met selected requirements:<br>• Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.<br>• Facility managers ensured appropriate privileges for licensed independent practitioners.<br>• Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation.<br>• Facility managers properly maintained licensed independent practitioners' folders. | • None of the 22 licensed practitioners whose folders we reviewed had EAM privileges that were appropriate for their training. | **1.** We recommended that facility managers ensure that licensed practitioners who perform emergency airway management have the appropriate training. |
| | Observation bed use met selected requirements:<br>• The facility gathered data regarding appropriateness of observation bed usage.<br>• The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more. | | |
| | The process to review resuscitation events met selected requirements:<br>• An interdisciplinary committee reviewed episodes of care where resuscitation was attempted.<br>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.<br>• The facility collected data that measured performance in responding to events. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| X | The surgical review process met selected requirements:<br>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.<br>• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement.<br>• The Surgical Work Group reviewed additional data elements. | • The Surgical Work Group only met 10 times over the past 12 months. | **2.** We recommended that the Surgical Work Group meet monthly. |
| | Clinicians appropriately reported critical incidents. | | |
| | The safe patient handling program met selected requirements:<br>• A committee provided program oversight.<br>• The committee gathered, tracked, and shared patient handling injury data. | | |
| | The process to review the quality of entries in the EHR met selected requirements:<br>• A committee reviewed EHR quality.<br>• A committee analyzed data at least quarterly.<br>• Reviews included data from most services and program areas. | | |
| | The policy for scanning internal forms into EHRs included the following required items:<br>• Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate.<br>• A correction process if scanned items have errors. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | • A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents. | | |
| | Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness. | | |
| | Overall, senior managers actively participated in performance improvement over the past 12 months. | | |
| | Overall, the facility had a comprehensive, effective QM program over the past 12 months. | | |
| | 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 emergency management.[b]

We inspected the 6N medical intensive care, 5N hospice/chemotherapy, 6S medical surgical, and locked MH units; the Emergency Department; and the medicine primary care, 3S hematology/oncology, and wound care clinics. Additionally, we reviewed relevant documents, including 10 employee training records, and 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. | | |
| X | The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques. | Past 2 quarters of fire drill documentation for health care occupancy buildings reviewed:<br>• All applicable buildings did not have at least one fire drill per shift per quarter. | **3.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance. |
| | The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements. | | |

| NM | Areas Reviewed for General EOC (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met fire safety requirements. | | |
| | The facility met environmental safety requirements. | | |
| X | The facility met infection prevention requirements. | • Neither of the two negative air pressure systems in the medicine primary care clinic airborne infection isolation rooms was functional. | **4.** We recommended that facility managers ensure negative air pressure systems in the medicine primary care clinic are functional and monitor compliance. |
| | The facility met medication safety and security requirements. | | |
| | The facility met privacy requirements. | | |
| X | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | VA National Center for Patient Safety MH EOC Checklist reviewed, which requires testing of panic alarms, including VA Police response time, on a periodic basis at a frequency determined by the facility. It also requires that furniture and equipment be secured or heavy enough to prevent it from being picked up, thrown, moved, or overturned.<br>• Although employees conducted stationary panic alarm testing on the locked MH unit, they did not document VA Police response time January–March 2015.<br>• A television bolted to a rolling cart on the locked MH unit was not secured or heavy enough to prevent it from being picked up, thrown, moved, or overturned. | **5.** We recommended that facility managers ensure locked mental health unit stationary panic alarm testing includes documentation of VA Police response time.<br>**6.** We recommended that equipment on the locked mental health unit is secured and heavy enough to prevent it from being picked up, thrown, moved, or overturned. |
| | **Areas Reviewed for SCI Center** | | |
| NA | The facility completed and documented required inspection checklists of all ceiling mounted patient lifts. | | |

| NM | Areas Reviewed for SCI Center (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | The facility met fire safety requirements in the SCI Center. | | |
| NA | The facility met environmental safety requirements in the SCI Center. | | |
| NA | The facility met infection prevention requirements in the SCI Center. | | |
| NA | The facility met medication safety and security requirements in the SCI Center. | | |
| NA | The facility met patient privacy requirements in the SCI Center. | | |
| NA | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Emergency Management** | | |
| | The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually. | | |
| | The facility maintained a list of resources and assets it may need during an emergency. | | |
| | The facility had a written Emergency Operations Plan that addressed key components. | | |
| | The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time. | | |
| | Employees received training and competency assessment on use of emergency evacuation devices. | | |
| | Evacuation devices were immediately accessible and in good repair. | | |

| NM | Areas Reviewed for Emergency Management (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | | |
| | **Areas Reviewed for Construction Safety** | | |
| NA | The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter. | | |
| NA | The facility complied with any additional elements required by VHA or local policy, or other regulatory standards. | | |

## Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. We inspected the Emergency Department and the surgical intensive care, post-anesthesia care, and 4N medical/surgical/telemetry units. Additionally, for these areas, we reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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 |
|---|---|---|---|
| | Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them. | | |
| | The facility required two signatures on controlled substances partial dose wasting. | | |
| | The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy. | | |
| | The facility prohibited storage of potassium chloride vials in patient care areas. | | |
| NA | If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors. | | |
| | The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications. | | |
| | The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes. | | |
| | The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy. | | |
| | The facility employed practices to prevent wrong-route drug errors. | | |
| | Medications prepared but not immediately administered contained labels with all required elements. | | |
| | The facility removed medications awaiting destruction or stored them separately from medications available for administration. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | The facility met multi-dose insulin pen requirements. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 39 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 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 |
|---|---|---|---|
| | A committee oversaw the facility's consult management processes. | | |
| | Major bed services had designated employees to:<br>• Provide training in the use of the computerized consult package<br>• Review and manage consults | | |
| | Consult requests met selected requirements:<br>• Requestors included the reason for the consult.<br>• Requestors selected the proper consult title.<br>• Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe. | | |
| | The facility met 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:<br>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance<br>• 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<br>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols<br>• 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 48 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had an AD policy that addressed:<br>• AD notification, screening, and discussions<br>• 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.<br>• Employees correctly posted patients' AD status. | | |
| X | Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs.<br>• When inpatients requested a discussion, employees documented the discussion and used the required AD note titles. | • Five of the 48 EHRs (10 percent), did not contain documentation that employees asked patients whether they wished to discuss creating, changing, and/or revoking ADs.<br>• Four of the six applicable EHRs did not contain documentation that employees held the discussions requested.<br>. | **7.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.<br>**8.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance. |
| | The facility met any additional elements required by VHA or local policy. | | |

## Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. 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 |
|---|---|---|---|
| | Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation. | | |
| | Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation. | | |
| NA | The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation.<br>• The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant. | | |
| | The facility complied with any additional elements required by VHA or local policy. | | |

## EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 22 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | The facility had a local EAM policy or had a documented exemption. | | |
| NA | If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise. | | |
| | Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM. | | |
| | Facility policy addressed key VHA requirements, including:<br>• Competency assessment and reassessment processes<br>• Use of equipment to confirm proper placement of breathing tubes<br>• A plan for managing a difficult airway | | |
| X | Initial competency assessment for EAM included:<br>• Subject matter content elements and completion of a written test<br>• Successful demonstration of procedural skills on airway simulators or mannequins<br>• Successful demonstration of procedural skills on patients | • None of the 22 clinicians had documentation of all required subject matter content elements. | **9.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required subject matter content elements and that facility managers monitor compliance. |

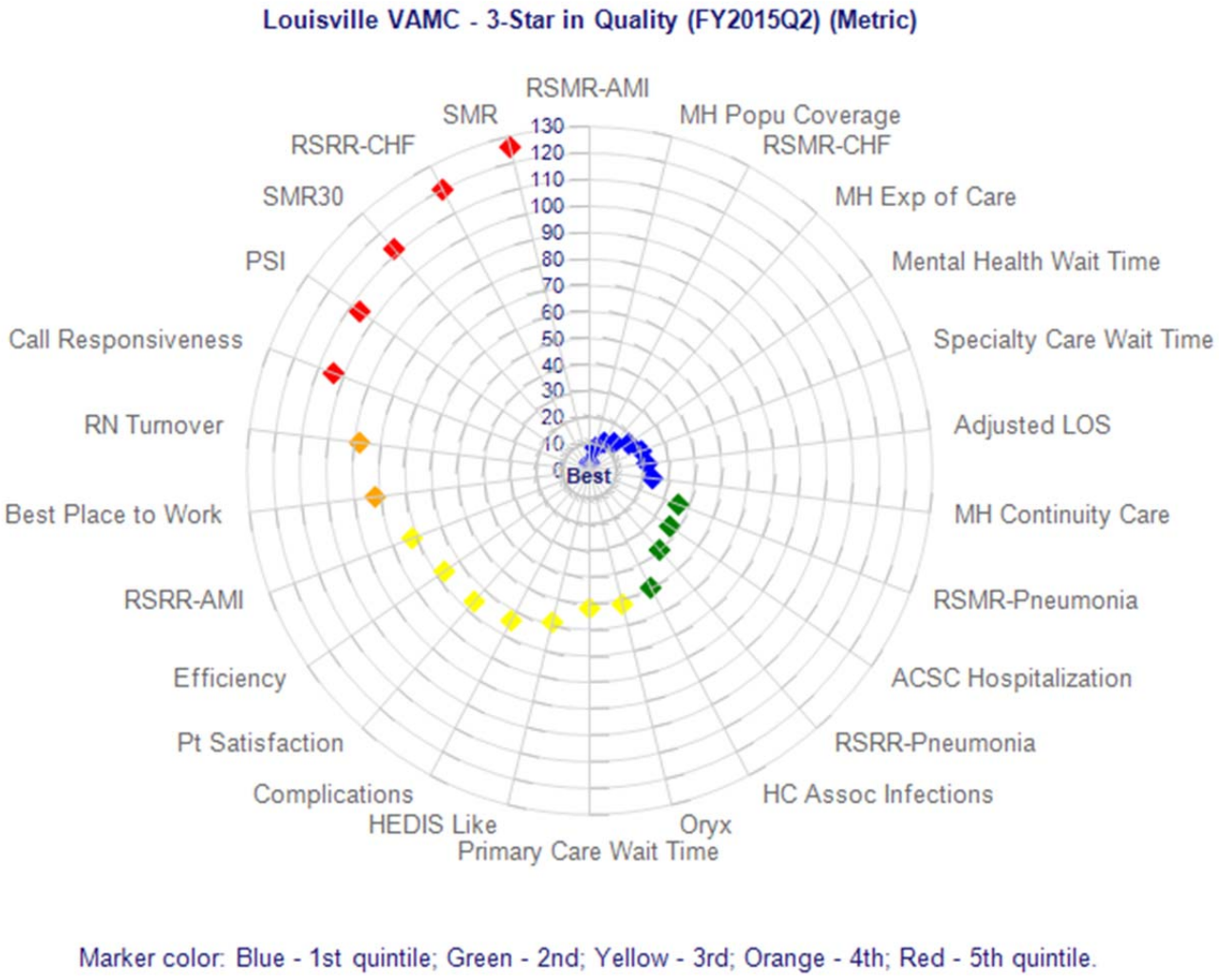
| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| NA | Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included:<br>• Review of clinician-specific EAM data<br>• Subject matter content elements and completion of a written test<br>• Successful demonstration of procedural skills on airway simulators or mannequins<br>• At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert<br>• A statement related to EAM if the clinician was not a licensed independent practitioner | | |
| | The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care. | | |
| | Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| X | The facility complied with any additional elements required by VHA or local policy. | Facility policy on out of operating room EAM reviewed:<br>• The facility did not require simulator training for reassessments.<br>• Facility oversight committee meeting minutes did not reflect a review of provider-specific EAM data as required by local policy. | **10.** We recommended that the facility revise the local policy for out of operating room emergency airway management to include successful demonstration of all required procedural skills on airway simulators for providers seeking renewal of privileges.<br>**11.** We recommended that the facility document the review of provider-specific emergency airway management data in Cardiopulmonary Review Committee meeting minutes. |

| Facility Profile (Louisville/603) FY 2015 through July 2015[1] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 1c-High complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $309 |
| **Number of:** | |
| • **Unique Patients** | 41,891 |
| • **Outpatient Visits** | 524,823 |
| • **Unique Employees**[2] | 1,694 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 107 |
| • **Community Living Center** | NA |
| • **MH** | 16 |
| **Average Daily Census:** | |
| • **Hospital** | 65 |
| • **Community Living Center** | NA |
| • **MH** | 13 |
| **Number of Community Based Outpatient Clinics** | 8 |
| **Location(s)/Station Number(s)** | Ft. Knox/603GA<br>New Albany/603GB<br>Louisville/603GC<br>Louisville/603GD<br>Louisville/603GE<br>Clarkson/603GF<br>Scottsburg/603GG<br>Carrollton/603GH |
| **VISN Number** | 9 |

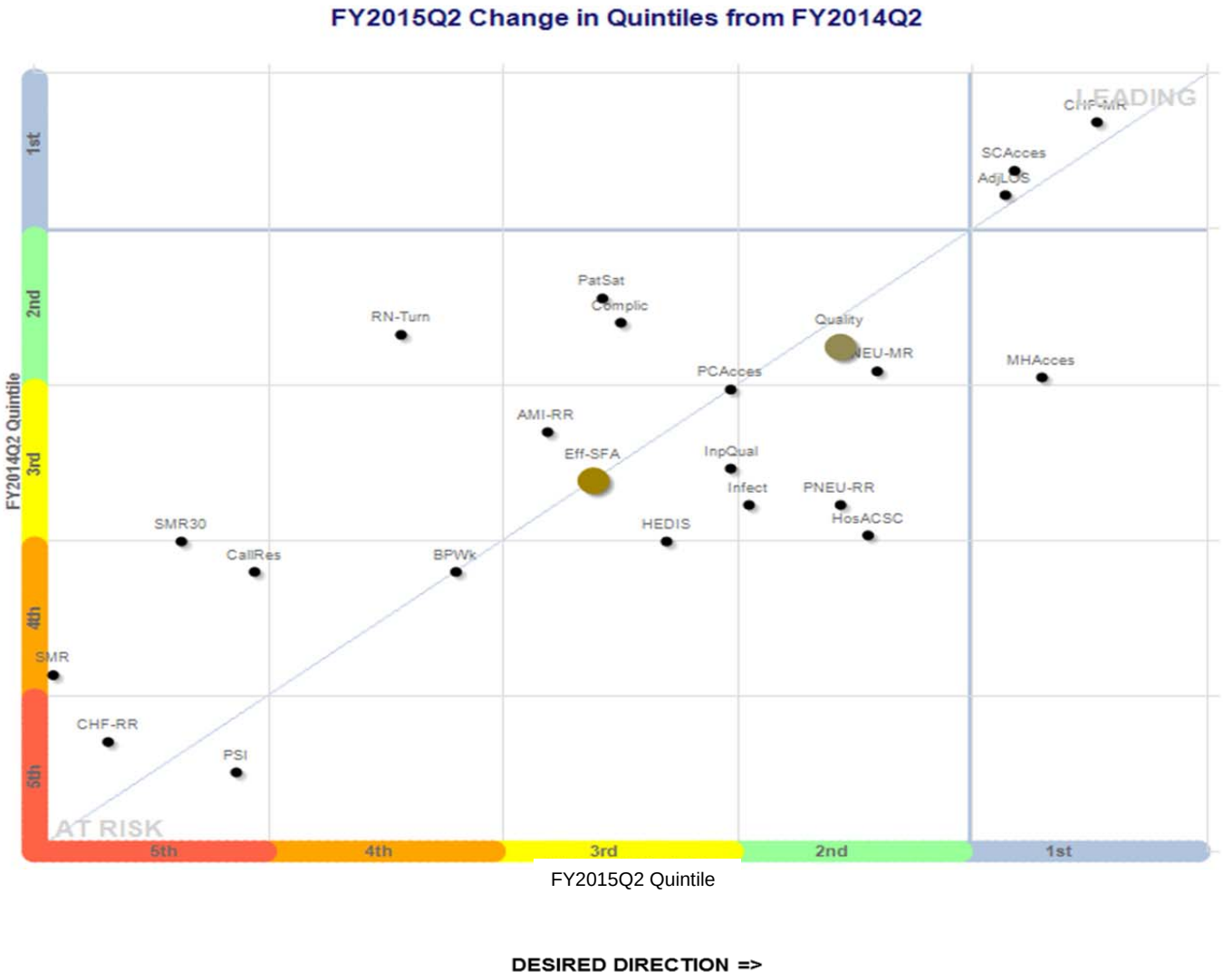
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

# 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 |

# VISN Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** August 28, 2015

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

**Subject:** **CAP Review of the Robley Rex VA Medical Center, Louisville, KY**

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

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

1. Attached, please find the comments and corrective action plan for the Combined Assessment Review (CAP) of the Robley Rex VA Medical Center, Louisville, Kentucky.

2. I have reviewed and concur with the responses and action plan submitted by the medical center.

3. If you have any questions or require additional information, please contact Ms. Cynthia L. Johnson, VISN 9 Quality Management Officer at 615-695-2143.

*(original signed by:)*
John E. Patrick
Network Director

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** August 28, 2015

**From:** Director, Robley Rex VA Medical Center (603/00)

**Subject:** **CAP Review of the Robley Rex VA Medical Center, Louisville, KY**

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

1. I want to express my appreciation to the Office of the Inspector General (OIG) survey team for their comprehensive review of the Robley Rex VAMC. We appreciated the professional and consultative nature of the review.

2. I have reviewed the report for the Robley Rex VAMC and I concur with the findings and recommendations.

3. Should you have any questions, please do not hesitate to contact Randy Johnson, Chief, Quality Management at 502-287-5331.

*(original signed by:)*
Martin Traxler
Medical Center Director

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that facility managers ensure that licensed practitioners who perform emergency airway management have the appropriate training.

Concur-Yes

Target date for completion: November 30, 2015

Facility response: The updated Medical Center Memorandum has been sent out for concurrence. A checklist is being used to monitor compliance with training. An Associate Chief of Education for residents and medical students was hired this year and will enhance communication between the program and the academic affiliate.

**Recommendation 2.** We recommended that the Surgical Work Group meet monthly.

Concur-Yes

Target date for completion: December 31, 2015

Facility response: The work group has met monthly since December, 2014 and they will continue to do so.

**Recommendation 3.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

Concur-Yes

Target date for completion: December 31, 2015

Facility response: Facility managers will promote and ensure better coordination with Services to increase fire drill participation. The Occupancy Matrix and Fire Drill Frequency will be updated and added to the Annual Review to ensure compliance. The data will be presented to the Environment of Care committee quarterly.

**Recommendation 4.** We recommended that facility managers ensure negative air pressure systems in the medicine primary care clinic are functional and monitor compliance.

Concur-Yes

Target date for completion: October 31, 2015

Facility response: The new monitor has been installed on room D-124, alarm points have been programmed and is functioning as designed. A new lock and key has been ordered for D-122.

**Recommendation 5.** We recommended that facility managers ensure locked mental health unit stationary panic alarm testing includes documentation of VA Police response time.

Concur-Yes

Target date for completion: October 31, 2015

Facility response: The VA Police's response time to the panic alarm testing will now be recorded as required.

**Recommendation 6.** We recommended that equipment on the locked mental health unit is secured and heavy enough to prevent it from being picked up, thrown, moved, or overturned.

Concur-Yes

Target date for completion: August 11, 2015

Facility response: The previously mobile TV cart has been bolted to the dining room wall.

**Recommendation 7.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur-Yes

Target date for completion: August 26, 2015

Facility response: A new clinical reminder will be implemented, to be completed by the nurse upon admission. The clinical reminder will include the following three yes or no questions: 1. Do you have an advanced directive?; 2. Do you have a copy of your advanced directive?; 3. Do you wish to discuss creating, changing and/or revoking your Advanced Directive? A yes response to questions 2 or 3 will generate an Advanced Directive consult to Social Work Service. Compliance will be monitored by the Chief of

Social Work Service or designee and the Chief of Health Information Management (HIMS). Results will be reported monthly to the HIMS Committee.

**Recommendation 8.** We recommended that employees hold advance directive discussions requested by inpatients and document the discussions and that facility managers monitor compliance.

Concur-Yes

Target date for completion: August 26, 2015

Facility response: A new clinical reminder is being implemented which will allow an Advanced Directive consult to be generated to Social Work Service when the Veteran indicates they have a copy of their Advanced Directive or if they request an Advanced Directive discussion. Compliance will be monitored by the Chief of Social Work Service or designee and the Chief of HIMS. Results will be reported monthly to the HIMS Committee.

**Recommendation 9.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required subject matter content elements and that facility managers monitor compliance.

Concur-Yes

Target date for completion: September 1, 2015

Facility response: The memorandum was updated and sent out for concurrence on August 18, 2015. The Medical Staff Office will monitor all providers with Out-of-OR Airway Management (OOORAM) privileges for compliance before approving the privilege/certification initially and at renewal which occurs every 2 years. The residents will be reviewed initially and at recertification by the Medical Staff Coordinator and followed by the Resident Education Office.

**Recommendation 10.** We recommended that the facility revise the local policy for out of operating room emergency airway management to include successful demonstration of all required procedural skills on airway simulators for providers seeking renewal of privileges.

Concur-Yes

Target date for completion: September 30, 2015

Facility response: The Medical Center Memorandum has been updated and is out for concurrence. The process is already taking place.

**Recommendation 11.** We recommended that the facility document the review of provider-specific emergency airway management data in Cardiopulmonary Review Committee meeting minutes.

Concur-Yes

Target date for completion: December 31, 2015

Facility response: Provider-specific complications have been analyzed and will be provided to each Service for ongoing professional practice evaluations beginning with the August 20, 2015 meeting.

# 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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# Report Distribution

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U.S. House of Representatives: Andy Barr, S. Brett Guthrie, Thomas Massie, Harold Rogers, Ed Whitfield, John A. Yarmuth

This report is available at **www.va.gov/oig**.

# Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- 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, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] 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] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.