Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02076-13

Combined Assessment Program Review of the Robert J. Dole VA Medical Center Wichita, Kansas

November 3, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Robert J. Dole VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
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 11, 2014.

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

- Medication Management
- Coordination of Care

Recommendations: We made recommendations in the following five activities:

Quality Management: Consistently complete actions from peer reviews, and report them to the Peer Review Committee. Revise the local observation bed policy to include how the responsible provider is determined and that each observation patient must have a focused goal for the observation period. Ensure code reviews include screening for clinical issues prior to the code that may have contributed to the code occurrence. Require the Surgical Work Group to meet monthly, consistently include all required members, and document its review of National Surgical Office reports. Review the quality of entries in the electronic health record at least quarterly. Include the handling of external source documents in the quality control policy for scanning. Ensure that the Transfusion Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings and that the blood/transfusions usage review process consistently includes the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

Environment of Care: Ensure patient care areas are clean. Promptly remove expired medications from patient care areas. Ensure post-anesthesia care unit employees do not consume beverages in treatment areas.

Acute Ischemic Stroke Care: Revise the stroke policy to address data gathering for analysis and improvement. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on the intensive care unit, on the medical/surgical unit, and in the community living center. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Ensure employees involved in assessing and treating stroke patients receive the training required by the facility.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Document resident progress towards restorative nursing goals. Document

the reasons for discontinuing or not providing restorative nursing services when those services are care planned. Provide all care planned/ordered assistive eating devices to residents for use during meals.

Magnetic Resonance Imaging Safety: Conduct contrast reaction emergency drills in magnetic resonance imaging (MRI). Complete secondary patient safety screenings prior to MRI. Ensure secondary patient safety screening forms are signed by the patient, family member, or caregiver. Require that radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan. Ensure all designated Level 2 MRI personnel receive annual level-specific MRI safety training.

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 21–30, for the full text of the Directors' comments.) We consider recommendations 2 and 13 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 seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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 2013 and FY 2014 through August 15, 2014, and was done 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 Robert J. Dole VA Medical Center, Wichita, Kansas,* Report No. 12-03073-57, December 7, 2012).

During this review, we presented crime awareness briefings for 82 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. An electronic survey was made available to all facility employees, and 345 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

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, EHRs, 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
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Six months of PRC meeting minutes reviewed: • None of the 19 actions expected to be completed were reported to the PRC.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	• The facility's policy did not include how the responsible provider is determined and that each observation patient must have a focused goal for the period of observation.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Twelve months of Critical Care Meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 10 times over the past 12 months. Ten months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff and operating room manager were not consistently listed as members. • There was no evidence that National Surgical Office reports were reviewed for 3 of 4 quarters.
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	• There was no evidence that the quality of entries in the EHR was reviewed.
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include the handling of external source documents.

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Transfusion Committee meeting minutes reviewed: • Clinical representatives from Surgery and Medicine Service attended only two of four meetings, and a clinical representative from Anesthesia Service did not attend any meetings. • The review process did not consistently include the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

2. We recommended that the local observation bed policy be revised to include how the responsible provider is determined and that each observation patient must have a focused goal for the period of observation.

3. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

4. We recommended that the Surgical Work Group meet monthly, consistently include the Chief of Staff and operating room manager as members, and document its review of National Surgical Office reports.

5. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed at least quarterly.

6. We recommended that the quality control policy for scanning include the handling of external source documents.

7. We recommended that processes be strengthened to ensure that the Transfusion Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings and that the blood/transfusions usage review process consistently includes the results of proficiency testing, the results of peer reviews when transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

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 and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected inpatient units (CLC, intensive care, and medical/surgical), outpatient clinics (eye, oncology, primary care, and pulmonology), the emergency department, the PACU, and SDS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 26 employee training records (15 SDS, 6 PACU, and 5 eye clinic). 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
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• Two of seven patient care areas were in need of cleaning.
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• We found expired medications in one of seven patient care areas.
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	SDS medical laser safety requirements were met.	
X	Infection prevention requirements in SDS and on the PACU were met.	• We found evidence of employee beverage consumption in the PACU treatment area.
X	Medication safety and security requirements in SDS and on the PACU were met.	• We found expired medications on the PACU.
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

8. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that post-anesthesia care unit employees do not consume beverages in treatment areas and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 15 patients who experienced stroke symptoms, and 10 employee training records (5 emergency department and 5 medical/surgical unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, intensive care unit, medical/surgical unit, and CLC. 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
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility's policy/plan/guideline did not address data gathering for analysis and improvement.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Fourteen of the 15 EHRs did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the inpatient units and in the CLC.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Two of the 11 applicable EHRs did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 11 applicable EHRs contained documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• There was no evidence that seven employees had completed the training required by the facility.
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that the facility's stroke policy be revised to address data gathering for analysis and improvement, that the policy be fully implemented, and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

13. We recommended that stroke guidelines be posted on the intensive care unit, on the medical/surgical unit, and in the community living center.

14. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

15. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 12 EHRs of residents (9 residents receiving restorative nursing services and 3 residents not receiving restorative nursing services but candidates for services). We also observed nine residents during two meal periods, reviewed one employee training/competency record and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In eight of the nine applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In two of the eight applicable EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• None of the eight applicable EHRs where restorative nursing services were care planned but were not provided or were discontinued reflected the reasons.
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
X	Care planned/ordered assistive eating devices were provided to residents at meal times.	• Nine of the 33 assistive eating devices (27 percent) care planned/ordered were not provided to residents.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

17. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

20. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 45 employees (30 randomly selected Level 1 ancillary staff and 15 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. 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
X	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• Contrast reaction emergency drills were not conducted in the MRI area.
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Twelve of the 35 EHRs (34 percent) did not contain secondary patient safety screenings prior to MRI. • Three of the applicable 23 secondary patient safety screening forms were not signed by the patient, family member, or caregiver prior to MRI.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Twenty of the 25 applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Two Level 2 MRI personnel did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

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

Recommendations

21. We recommended that processes be strengthened to ensure that contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

22. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

23. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are signed by the patient, family member, or caregiver and that compliance be monitored.

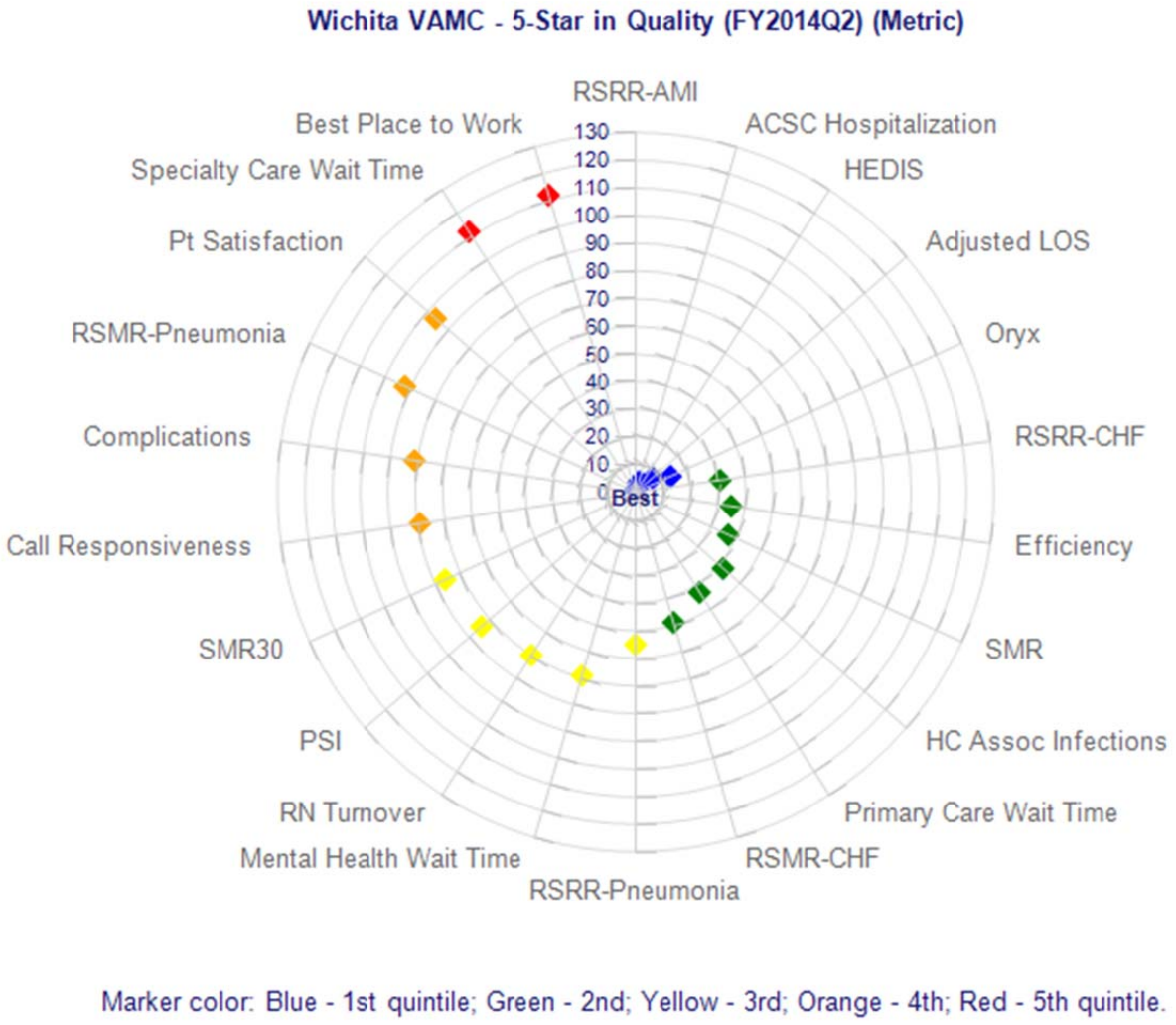
24. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

25. We recommended that processes be strengthened to ensure that all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Facility Profile (Wichita/589A7) FY 2014 through July 2014[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$188
Number of:	
• **Unique Patients**	26,045
• **Outpatient Visits**	260,635
• **Unique Employees**[2]	745
Type and Number of Operating Beds:	
• **Hospital**	41
• **CLC**	40
• **MH**	NA
Average Daily Census (June 2014):	
• **Hospital**	23
• **CLC**	30
• **MH**	NA
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Dodge City/589G2 Liberal/589G3 Hays/589G4 Parsons/589G5 Hutchinson/589G7 Salina/598GW
VISN Number	15

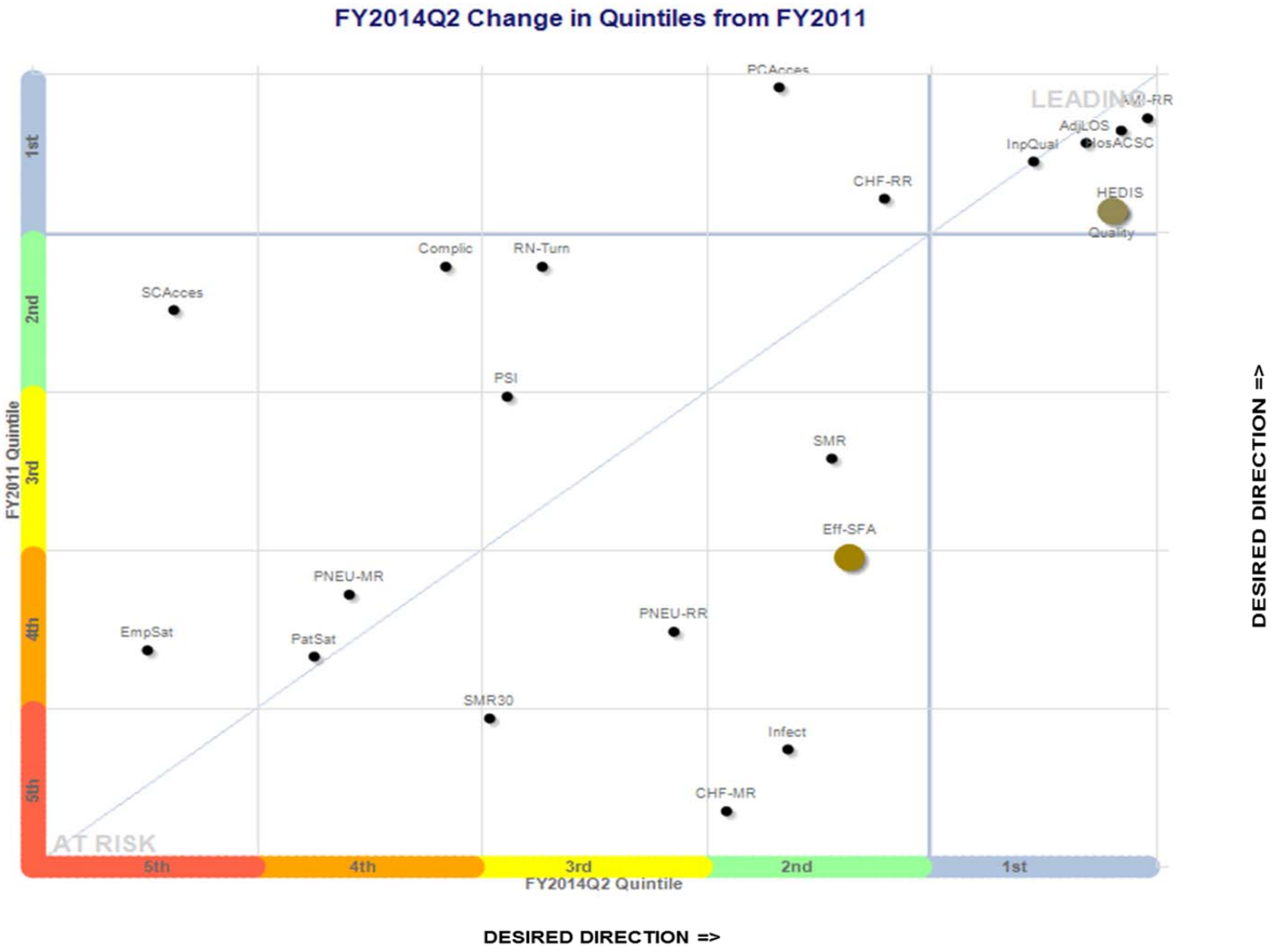
[1] All data is for FY 2014 through July 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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 Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	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
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	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: October 6, 2014

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Robert J. Dole VA Medical Center, Wichita, KS**

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

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

Attached, please find the initial status response for the Combined Assessment Program Review for the Robert J. Dole VA Medical Center, Wichita, KS (Conducted the week of August 11, 2014).

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity to focus on continuous performance improvement.

For additional questions, please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at 816-701-3000.

(*original signed by:)*
WILLIAM P. PATTERSON, MD, MSS
Network Director
VA Heartland Network (VISN15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 3, 2014

From: Director, Robert J. Dole VA Medical Center (589A7/00)

Subject: **CAP Review of the Robert J. Dole VA Medical Center, Wichita, KS**

To: Director, VA Heartland Network (10N15)

I have reviewed the findings and concur with the recommendations.

Corrective actions are in process.

The Point of Contact for any questions or clarification is Mary Steiner 316-685-2221 ext. 54601.

FRANCISCO VAZQUEZ, MBA
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 processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Concur

Target date for completion: January 2, 2015

Facility response: On September 9, 2014 the Risk Manager officially instituted a new process for tracking follow up of Level 2 and 3 cases in the Peer Review minutes. Each Service Director's feedback will be listed uniquely with the date of completion and the action taken by the Service Director. Tracking of Peer Review System Issues follow-up will remain the same and will be addressed in the minutes as an individual line item until completion. The National Tool for System Issues is used and placed within the agenda as an attachment.

Recommendation 2. We recommended that the local observation bed policy be revised to include how the responsible provider is determined and that each observation patient must have a focused goal for the period of observation.

Concur

Target date for completion: September 9, 2014

Facility response: The local observation bed policy was revised to include "admitting/attending physician on call" as the responsible provider. The "Attachment A" that includes the focused goals for observation beds was attached to the observation bed policy. The policy was approved by Clinical Practice Council and Executive Council in September 2014.

Recommendation 3. We recommended that processes be strengthened to ensure that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: December 1, 2014

Facility response: Effective August 27, 2014, the facility Critical Care Committee minutes expanded its review and discussion to include the clinical screening details of

each Code Blue and Rapid Response Team incident. Compliance with these actions is reported monthly to the Clinical Practice Council.

Recommendation 4. We recommended that the Surgical Work Group meet monthly, consistently include the Chief of Staff and operating room manager as members, and document its review of National Surgical Office reports.

Concur

Target date for completion: January 31, 2015

Facility response: The Surgical Work Group has scheduled monthly meetings and has revised the agenda and minutes to document appropriate staff attendance, including the Chief of Staff and Operating Room Nurse Manager. The National Surgical Office reports are also discussed and documented.

Recommendation 5. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed at least quarterly.

Concur

Target date for completion: February 28, 2015

Facility response: The new Medical Records Informatics Committee will have oversight of medical records documentation. Quality items to be reviewed will be determined by the Committee and monthly reports will be submitted to the Quality Performance Council.

Recommendation 6. We recommended that the quality control policy for scanning include the handling of external source documents.

Concur

Target date for completion: February 28, 2015

Facility response: The facility has added quality control for the handling of external source documents to the Center Circular Information Management Council 13-06. Monthly compliance reports will be submitted to the Quality Performance Council.

Recommendation 7. We recommended that processes be strengthened to ensure that the Transfusion Committee members from Surgery, Medicine, and Anesthesia Services consistently attend meetings and that the blood/transfusions usage review process consistently includes the results of proficiency testing, the results of peer reviews when

transfusions did not meet criteria, and the results of inspections by government or private (peer) entities.

Concur

Target date for completion: February 28, 2015

Facility response: The Transfusion Committee membership was expanded in July 2014 to include key clinical members of Surgery, Medicine, and Anesthesia Services. The time of the quarterly meeting has been changed to 3:30PM to accommodate attendees; and attendance expectations were discussed with members. The blood/transfusion meeting agenda was modified to add as standing items the: results of proficiency testing; results of peer reviews when transfusions didn't meet criteria; and results of all inspections by government or private (peer) entities.

Recommendation 8. We recommended that processes be strengthened to ensure that patient care areas are clean and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: The two patient care areas identified were cleaned by Environmental Management Services the same day. Staff reassignments have been made and additional staff added to the Environmental Management Service. A Quality Control Checklist has been added to daily rounds. In addition, weekly Environment of Care rounds are attended by the Chief of Environmental Management Services and reports to the Environment of Care Committee. Compliance monitors will be submitted to Quality Performance Council.

Recommendation 9. We recommended that processes be strengthened to ensure that expired medications are promptly removed from patient care areas and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: Weekly Pyxis reports will be run by Pharmacy staff. This includes medications that are near expiration and are then replaced. In addition, a Pharmacist will conduct random, unannounced checks. The Nurse Managers of the patient care areas complete monthly Manager Checklists which includes expired medication removal. Compliance monitors will be completed by Pharmacy and Nurse Managers and reported to Quality Performance Council.

Recommendation 10. We recommended that processes be strengthened to ensure that post-anesthesia care unit employees do not consume beverages in treatment areas and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: An email was sent to all staff on August 18, 2014 clarifying the appropriate locations for staff food/drink. Patient care areas are monitored using the Nurse Manager Checklist for compliance, with reports sent to the Quality Performance Council.

Recommendation 11. We recommended that the facility's stroke policy be revised to address data gathering for analysis and improvement, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The facility Center Circular Clinical Practice Council 14-42, Evaluation and Treatment of Acute Ischemic Stroke Patients was revised to include the data to be gathered and analyzed. It was approved October 1, 2014. Compliance will be monitored and reported by the Stroke Committee to the Quality and Performance Council.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The facility Center Circular Clinical Practice Council 14-42, Evaluation and Treatment of Acute Ischemic Stroke Patients, clarified that the provider is responsible for completion of the National Institutes of Health Stroke Scale prior to transfer. It was approved October 1, 2014. Compliance monitoring is being submitted to the Stroke Committee and the Quality Performance Council monthly.

Recommendation 13. We recommended that stroke guidelines be posted on the intensive care unit, on the medical/surgical unit, and in the community living center.

Concur

Target date for completion: August 20, 2014

Facility response: The Stroke Guidelines were posted in the areas of Medical/Surgical, Intensive Care Unit, Community Living Center, and Post Anesthesia Recovery Room on August 20, 2014. Pictures of postings were shared with Office of Inspector General surveyors.

Recommendation 14. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: December 31, 2014

Facility response: The Emergency Department clinicians will now screen patients for difficulty swallowing prior to oral intake. The Center Circular Clinical Practice Council 14-42, Evaluation and Treatment of Acute Ischemic Stroke Patients was updated to include dysphagia screening prior to oral intake. It was approved October 1, 2014. Compliance monitoring is being submitted to the Stroke Committee and the Quality Performance Council monthly.

Recommendation 15. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The Stroke brochures have been printed and placed in patient care areas. Emergency Department Staff and Intensive Care Unit staff have been educated regarding these brochures and will give them to patient/family/caregivers as appropriate upon discharge and document it in the patient's electronic medical record. Monitoring will be part of the monthly stroke data shared with the Stroke Committee and the Quality Performance Council.

Recommendation 16. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The Center Circular Clinical Practice Council 14-42, Evaluation and Treatment of Acute Ischemic Stroke Patients, has now defined the appropriate staff to receive National Institute of Health Stroke Certification. Current staff of the Intensive Care Unit, Emergency Department clinical staff (Registered Nurses and providers), Hospitalists, and Attending Physicians will complete the stroke certification within three months and new hires within six weeks. The circular was approved

October 1, 2014. Compliance will be monitored by the Education Department with reports submitted to the Stroke Committee and the Quality Performance Council.

Recommendation 17. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: The Community Living Center Standard Operating Procedure 2014-10, Restorative Nursing Care Program, was revised on October 3, 2014, to reflect current and appropriate documentation of restorative care. Staff is being educated by the Restorative Care Coordinator. Documentation compliance will be monitored and submitted monthly to the Quality Performance Council.

Recommendation 18. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: The Community Living Center Standard Operating Procedure 2014-10, Restorative Nursing Care Program, has been updated and approved on October 3, 2014 to reflect current restorative practice with nursing goals being individualized and revised as needed. The staff will be educated regarding the use of the Restorative Care note that includes the resident's progress toward his/her goals. Monitoring for compliance will be submitted monthly to the Quality Performance Council.

Recommendation 19. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: The restorative staffing plan is being implemented. Restorative training/education will be provided to all staff in the Community Living Center in order to facilitate documentation of the reasons for discontinuing or not providing restorative services. Compliance monitoring is submitted monthly to Quality Performance Council.

Recommendation 20. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: February 28, 2015

Facility response: The Community Living Center staff will monitor to see that residents have the care planned/ordered assistive eating devices for use during meals. The results of the compliance monitor will be sent to the Quality Performance Council.

Recommendation 21. We recommended that processes be strengthened to ensure that contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: August 28, 2015

Facility response: A contrast reaction drill was conducted with all Magnetic Resonance Imaging Staff, Supervising Radiologist, and Radiology Supervisor present on August 28, 2014. This will be conducted and documented annually.

Recommendation 22. We recommended that processes be strengthened to ensure that secondary patient safety screenings are completed immediately prior to magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: February 28, 2015

Facility response: The secondary patient safety screenings will be completed prior to Magnetic Resonance Imaging. All secondary patient safety screenings will be scanned into the patient record within 24 hours. Compliance monitoring will be submitted monthly to the Magnetic Resonance Imaging Committee and the Quality Performance Council.

Recommendation 23. We recommended that processes be strengthened to ensure that secondary patient safety screening forms are signed by the patient, family member, or caregiver and that compliance be monitored.

Concur

Target date for completion: February 28, 2015

Facility response: The secondary patient safety screening forms will be signed and dated by the patient, family member, or caregiver and witnessed by the technologist

prior to Magnetic Resonance Imaging. All secondary patient safety screenings will be scanned into the patient record within 24 hours. Compliance monitoring will be submitted monthly to the Magnetic Resonance Imaging Committee and the Quality Performance Council.

Recommendation 24. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: February 28, 2015

Facility response: The radiologists and/or Level 2 Magnetic Resonance Imaging personnel created a Magnetic Resonance Safety Note in order to document all identified contraindications prior to the scan. Compliance will be monitored and submitted monthly to the Magnetic Resonance Imaging Committee and the Quality Performance Council.

Recommendation 25. We recommended that processes be strengthened to ensure that all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: November 30, 2014

Facility response: All designated Level 2 Magnetic Resonance Imaging personnel will complete Level 2 training which is a Digital Video Disc manufactured by General Electric, "Quench Your Thirst for Magnetic Resonance Safety". The Talent Management System will assign the education for designated Level 2 staff annually. Documentation of completion will be recorded in the Talent Management System and monthly reports are sent to area supervisors by the Education Department.

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- 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*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.