Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00600-33

Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

November 10, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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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	John J. Pershing VA Medical Center
FY	fiscal year
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

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 September 14, 2015.

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

- Medication Management
- Advance Directives

The facility's reported accomplishment was increased veteran outreach.

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

Quality Management: Ensure licensed independent practitioners who perform emergency airway management have the appropriate skills and training and the privileges to do so. Review, sign, and date emergency airway management privileges for licensed independent practitioners prior to granting the privileges. Ensure the Cardiopulmonary Resuscitation Committee reviews all episodes of care where resuscitation was attempted. Require the recently established Safe Patient Handling Committee to continue to meet and provide oversight of the safe patient handling program.

Environment of Care: Ensure all sharps containers are sealed tightly at the point of collection. Require that evacuation devices are immediately accessible in patient care areas. For all construction projects, initiate Interim Life Safety Measures as required and post any needed alternative exit signage.

Coordination of Care: Ensure requestors consistently select the proper consult title. Consistently complete inpatient consults within the specified timeframe.

Computed Tomography Radiation Monitoring: Revise the computed tomography policy to include a quality control program.

Emergency Airway Management: Revise the emergency airway management policy to include a plan to manage a difficult airway. Ensure initial clinician emergency airway management competency assessment includes all required elements. Require that a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care. Strengthen processes to minimize a repeat occurrence in which a non-privileged

clinician performs an intubation, and in instances of occurrence, initiate root cause analyses.

Follow-Up on Long-Term Home Oxygen Therapy: Assess all home oxygen patients for continuation of home oxygen within 90 days of the initial order.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–33, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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 and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- EAM
- Follow-Up on Long-Term Home Oxygen Therapy

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 September 18, 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 John J. Pershing VA Medical Center, Poplar Bluff, Missouri,* Report No. 13-00273-147, March 26, 2013. We made a repeat recommendation in long-term home oxygen therapy.

During this review, we presented crime awareness briefings for 90 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 262 responses. We shared summarized results with facility managers.

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

Reported Accomplishment

Veteran Outreach

The facility expanded its veteran outreach efforts over the past year. It added an open house for all veterans considering enrolling for benefits and services. Additionally, a special event called “214 Day” encourages veterans to bring their DD-214 military release papers for documenting with local county recorders. As a result of these events, which include other VA partners, the facility reports reaching 1,000 people with information about VA benefits and services.

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, 10 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. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • 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: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Of the 10 licensed independent practitioners' folders reviewed: o Two practitioners' EAM privileges were not appropriate for their skills and training. o Two practitioners who were providing EAM services did not have privileges to do so. o Six practitioners' EAM privileges were not reviewed, signed, and dated prior to granting the privileges.	**1.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the appropriate skills and training. **2.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the privileges to do so. **3.** We recommended that facility managers ensure emergency airway management privileges for licensed independent practitioners are reviewed, signed, and dated prior to granting the privileges.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.	Twelve months of Cardiopulmonary Resuscitation Committee meeting minutes reviewed: • The committee did not review each episode.	**4.** We recommended that the Cardiopulmonary Resuscitation Committee review all episodes of care where resuscitation was attempted.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
NA	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program until July 2015.	**5.** We recommended that the facility ensure the recently established Safe Patient Handling Committee continues to meet and provide oversight of the safe patient handling program.
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and irretrievability 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 acute care inpatient unit, the community living center, outpatient clinics (primary care and specialty), and the urgent care clinic. Additionally, we reviewed relevant documents, including 10 employee training and competency 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.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on disposal of needles, syringes, and sharps reviewed, which requires that "puncture resistant containers must be sealed tightly at point of collection." • Two patient care areas had unsealed sharps containers.	**6.** We recommended that facility managers ensure all sharps containers are sealed tightly at the point of collection and monitor compliance.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
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.		

NM	Areas Reviewed for Emergency Management	Findings	Recommendations
	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.		
X	Evacuation devices were immediately accessible and in good repair.	• In two patient care areas, evacuation devices were stored behind other patient care equipment and were not immediately accessible.	**7.** We recommended that facility managers ensure evacuation devices are immediately accessible in patient care areas and monitor compliance.
	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.		

NM	Areas Reviewed for Construction Safety (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	VHA policy reviewed, which requires the assessment and implementation of Interim Life Safety Measures on all construction projects in accordance with Joint Commission standards. • The facility did not initiate Interim Life Safety Measures for the front entrance construction project. Joint Commission standards reviewed, which require the facility to post signage identifying the location of alternative exits. • The facility did not post signage identifying the location of alternative exits for the four exits that opened into the construction zone.	**8.** We recommended that for all construction projects, the facility initiate Interim Life Safety Measures as required and post any needed alternative exit signage and that facility managers monitor compliance.

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 12 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the community living center, acute care inpatient unit, and urgent care clinic and for these areas 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.		

	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 47 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. 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
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Thirty nine consult requests (83 percent) did not include "inpatient" in the title. • In five of the 46 applicable EHRs (11 percent), consultants did not change the statuses of the consult requests within the specified timeframe.	**9.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance. **10.** We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.
	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 eight CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
X	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans	• The facility's computed tomography policy did not include a quality control program.	**11.** We recommended that the facility revise the computed tomography policy to include a quality control program.

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 44 randomly selected patients who had an acute care admission 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 an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.		
	The facility met 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.[g]

We reviewed relevant documents, including competency assessment documentation of nine 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.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address a plan for managing a difficult airway.	**12.** We recommended that the facility revise the emergency airway management policy to include a plan to manage a difficult airway.
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• None of the nine clinicians had documentation of all required elements.	**13.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required 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: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • 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 • A statement related to EAM if the clinician was not a licensed independent practitioner		
X	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.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**14.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.
	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.	VHA policy on EAM reviewed, which requires the facility to perform a root cause analysis when a clinician without EAM privileges performs an intubation: • The facility had an instance where a non-privileged clinician performed an intubation, and there was no documentation of a root cause analysis.	**15.** We recommended that facility managers strengthen processes to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and in instances of occurrence, initiate root cause analyses.

Review Activity With Previous CAP Recommendations

Follow-Up on Long-Term Home Oxygen Therapy

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with long-term home oxygen requirements.[h]

Home Oxygen Patient Assessments. Local policy requires a designated practitioner to assess home oxygen program patients for continuation of home oxygen within 90 days of the initial order. During our previous CAP review, we found that practitioners did not consistently assess patients within 90 days. During this review, the facility reported that practitioners did not assess eight of 20 patients for continuation of home oxygen within 90 days of the initial order.

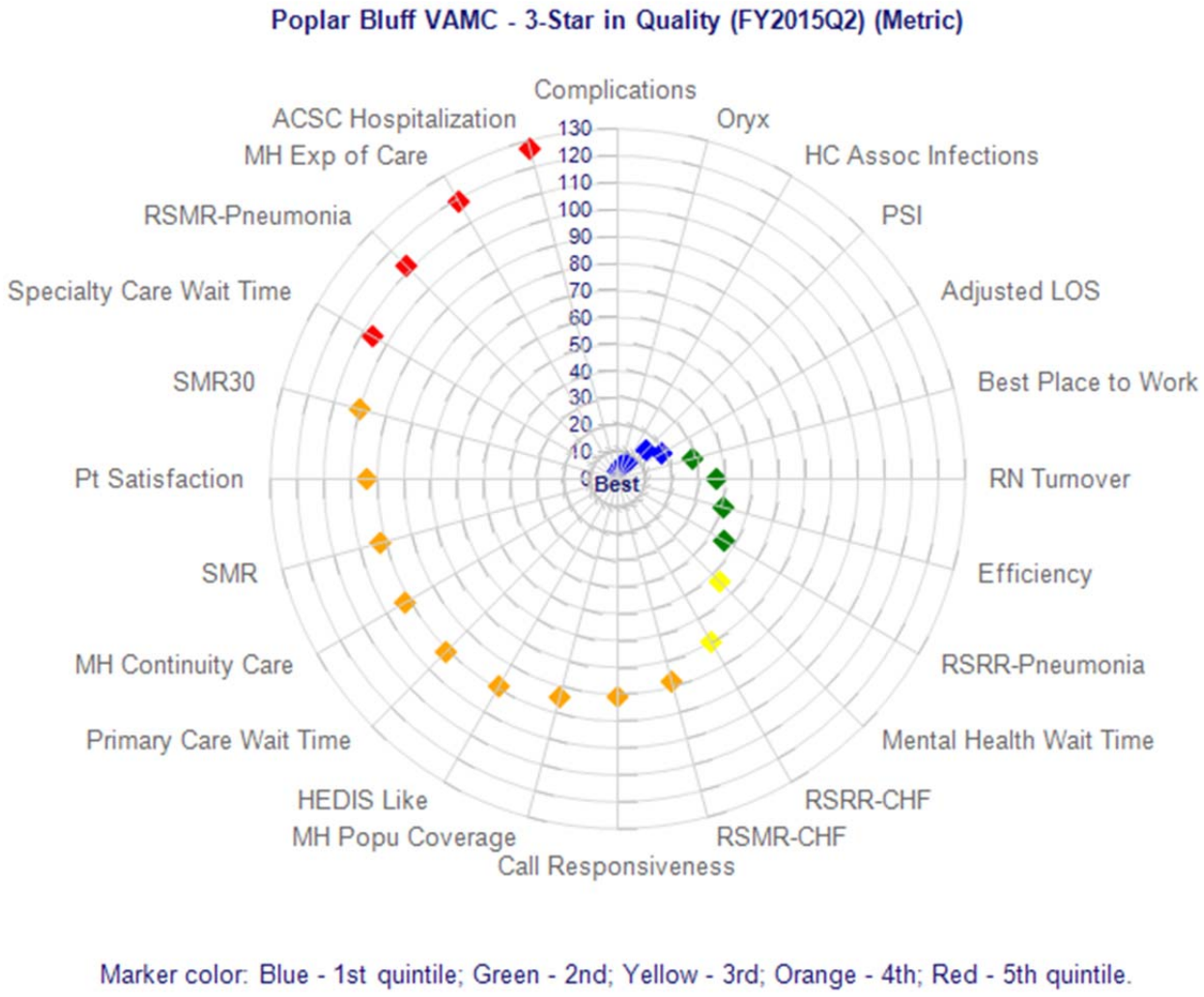
Recommendation

16. We recommended that the facility ensure all home oxygen patients are assessed for continuation of home oxygen within 90 days of the initial order and that facility managers monitor compliance.

Facility Profile (Poplar Bluff/657A4) FY 2015 through September 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$131
Number of:	
• **Unique Patients**	21,179
• **Outpatient Visits**	204,856
• **Unique Employees**[2]	644.64
Type and Number of Operating Beds:	
• **Hospital**	18
• **Community Living Center**	40
• **MH**	0
Average Daily Census:	
• **Hospital**	5
• **Community Living Center**	29
• **MH**	0
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	West Plains, MO/657GF Paragould, AR/657GG Cape Girardeau, MO/657GH Farmington, MO/657GI Salem, MO/657GN Sikeston, MO/657GV
Veterans Integrated Service Network Number	15

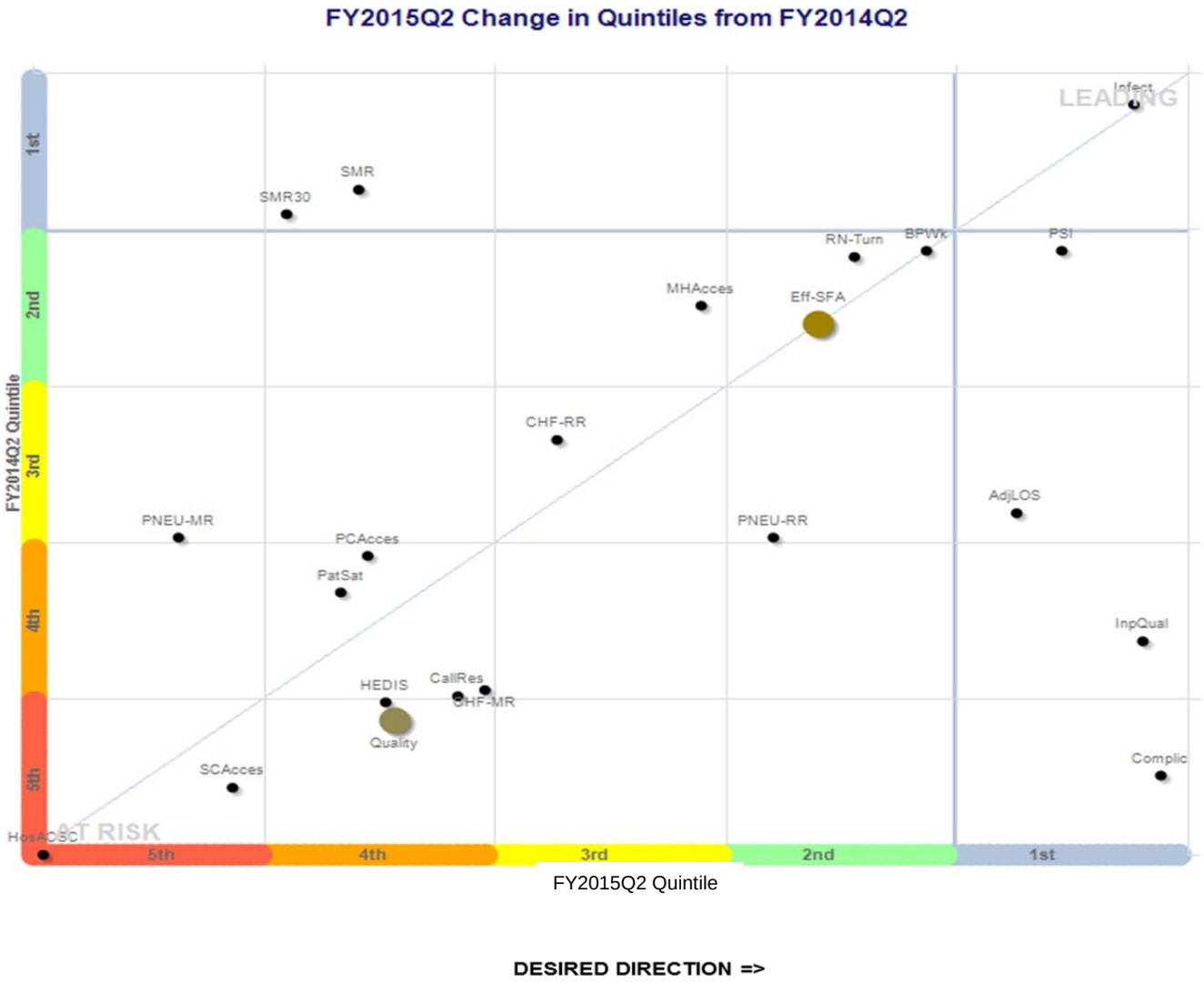
[1] All data is for FY 2015 through September 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: October 28, 2015

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

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

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

I have reviewed the draft report of the John J. Pershing VA Medical Center and I concur with the findings and recommendations.

WILLIAM P. PATTERSON, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 27, 2015

From: Interim Director, John J. Pershing VA Medical Center (657A4/00)

Subject: **CAP Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, VA Heartland Network (10N15)

1. I have reviewed the draft report of the Office of the Inspector General's (OIG) CAP review of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri. We concur with the findings and recommendations.

2. If you have questions or require additional information, please do not hesitate to contact Dawna Bader, Director of Performance Improvement, at 573-778-4280 or Dawna.Bader.va.gov.

3. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

Dawna Bader

Dawna Bader,
Acting 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 independent practitioners who perform emergency airway management have the appropriate skills and training.

Concur

Target date for completion: October 16, 2015

Facility response: A 100 percent review was conducted on providers who had privileges for emergency airway management (EAM) to determine if they had the appropriate skills and training to support EAM privileges. Providers privileged to perform EAM but lacking evidence of successful completion of all required elements either: a) completed all required training and underwent competency assessment, or b) if the training/ competency assessment had been successfully completed but the training record lacked documentation of successful completion, documentation was obtained from the evaluating physician. As a result, all providers who are privileged to perform EAM now have documentation of appropriate skills and training. Additionally, a QA checklist was implemented to verify that licensed independent practitioners who request privileges for EAM have documentation of completed training and assessment of competency.

Recommendation 2. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have the privileges to do so.

Concur

Target date for completion: December 31, 2015

Facility response: All providers that work in Urgent Care, provide MOD coverage, or perform moderate sedation will be required to be privileged in EAM to ensure sufficient coverage is available and to ensure that only privileged providers perform EAM.

Recommendation 3. We recommended that facility managers ensure emergency airway management privileges for licensed independent practitioners are reviewed, signed, and dated prior to granting the privileges.

Concur

Target date for completion: December 31, 2015

Facility response: A review was conducted on 100 percent of current licensed independent practitioners (LIPs), including those with EAM privileges, to ensure privileges were signed, dated and complete. Those that were found to be incomplete were administratively corrected, when appropriate, or they are being reappointed/reprivileged to correct identified deficiencies. Additionally, a QA review was implemented for all new appointments and reappointments to verify that privileges are complete prior to submission of the packet to Professional Standards Board (PSB), including (but not limited to) dates and signatures.

Recommendation 4. We recommended that the Cardiopulmonary Resuscitation Committee review all episodes of care where resuscitation was attempted.

Concur

Target date for completion: March 31, 2016

Facility response: The Cardiopulmonary Resuscitation Committee (CRC) reviews all episodes of care where resuscitation was attempted, but the reviews did not consistently include multidisciplinary team members. The CRC Chairperson will ensure multidisciplinary review of all future resuscitation events and track participation by discipline using an attendance tracker. Due to the low number of cardiopulmonary arrests at the facility, compliance will be demonstrated by reviewing two quarters of code blue and code white (rapid response team) cases, which will show that a multidisciplinary team conducted the reviews.

Recommendation 5. We recommended that the facility ensure the recently established Safe Patient Handling Committee continues to meet and provide oversight of the safe patient handling program.

Concur

Target date for completion: March 31, 2016

Facility response: The Safe Patient Handling (SPH) and Movement Committee meets on a quarterly basis and oversight of the SPH Committee is provided by the Environment of Care (EOC) Committee. Minutes of the SPH Committee will be monitored for two quarters to ensure that they met at least quarterly, and the EOC Committee minutes will be monitored for two quarters to ensure that they reflect the Committee's oversight role for the safe patient handling program.

Recommendation 6. We recommended that facility managers ensure all sharps containers are sealed tightly at the point of collection and monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Education regarding the requirements for keeping sharps boxes closed and the locking mechanism engaged was provided to staff in September 2015. Compliance will be monitored by the nurse manager and will be verified through weekly rounds by the Infection Control Nurse. Results of the weekly rounds will be reported and tracked through the Infection Control Committee until 90 percent compliance is reached for three months.

Recommendation 7. We recommended that facility managers ensure evacuation devices are immediately accessible in patient care areas and monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: The SPH Coordinator provided education to staff in September 2015 regarding the importance of unobstructed access to evacuation devices, and provides this education during competency assessments. The SPH will complete weekly observations of evacuation device storage areas to ensure that access is unobstructed. Results of the weekly rounds will be reported and tracked through the Environment of Care (EOC) Committee until 90 percent compliance is reached for three months.

Recommendation 8. We recommended that for all construction projects, the facility initiate Interim Life Safety Measures as required and post any needed alternative exit signage and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: A pre-construction risk assessment, which includes the Interim Life Safety Measures and signage, has been developed and will be completed prior to initiation of construction. Compliance of documentation of the pre-construction risk assessment will be monitored until 90 percent compliance is achieved for three months. Documentation of the pre-construction risk assessment will be reported in the Construction Safety Committee, with oversight by Environment of Care Committee.

Recommendation 9. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: To ensure requestors consistently select the proper consult title, “inpatient” has been added to consults that are utilized on an inpatient basis. The facility’s consult policy will be updated to address appropriate use of inpatient consult titles and providers will be educated on their use. A monthly audit of 30 inpatient consults (general medicine or observation status) will be completed by the Associate

Chief of Staff of Specialty Services or designee to ensure consults have the proper consult title. The audit will continue until a 90 percent compliance rate is reached for three months. Results of the audit will be reported to Consult Management Committee.

Recommendation 10. We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility response: Consult urgency options will be updated to reflect the most recent guidance received from VHA (two consult categories, Stat and Routine). Providers will receive education on the urgency options within a consult and the associated timeframes. A monthly audit of 30 inpatient consults will be completed by the Associate Chief of Staff of Specialty Services or designee to ensure consults are completed by the specified time frame. The audit will continue until a 90 percent compliance rate is reached for three months. Results of the audit will be reported to Consult Management Committee.

Recommendation 11. We recommended that the facility revise the computed tomography policy to include a quality control program.

Concur

Target date for completion: December 31, 2015

Facility response: The policy titled, "Quality Assurance/Risk Management Program for Radiology" was revised in October 2015 to include a quality control program for computed tomography. The policy is being circulated for feedback and approval.

Recommendation 12. We recommended that the facility revise the emergency airway management policy to include a plan to manage a difficult airway.

Concur

Target date for completion: December 31, 2015

Facility response: The policy titled, "Out of Operating Room Airway Management" was updated in October 2015 to include a plan for managing a difficult airway and is being circulated for feedback and approval.

Recommendation 13. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: September 23, 2015

Facility response: During the facility's review of the EAM program, items were found listed on the competency checklist that are not part of the required elements. Required elements are defined by the National Center for Patient Safety (NCPS) and these required elements were used to develop new EAM competencies. 100 percent of providers privileged to perform EAM but lacking evidence of successful completion of all required elements on the new EAM competency either: a) completed all required training and underwent competency assessment, or b) if the training/competency assessment had been successfully completed but the training record lacked documentation of successful completion, documentation was obtained from the evaluating physician. To monitor compliance, a concurrent QA review checklist was implemented to verify that licensed independent practitioners who request privileges for EAM have documentation of completed competency assessment that includes all required elements prior to submission of the file to the PSB.

Recommendation 14. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: All providers that work in Urgent Care, provide MOD coverage, or perform moderate sedation will be required to be privileged in EAM to ensure 24/7 coverage is available. Compliance with EAM privileges will be monitored by the Professional Standards Board.

Recommendation 15. We recommended that facility managers strengthen processes to minimize a repeat occurrence in which a non-privileged clinician performs an intubation, and in instances of occurrence, initiate root cause analyses.

Concur

Target date for completion: December 31, 2015

Facility response: Actions taken for recommendation #14 ensures that sufficient coverage is available so that only privileged providers are used to perform intubation. Additionally, the Out of Operating Room Airway Management policy has been updated

to require a root cause analysis (RCA) for instances when intubation is performed by a non-privileged provided; the policy is being circulated for feedback and approval.

Recommendation 16. We recommended that the facility ensure all home oxygen patients are assessed for continuation of home oxygen within 90 days of the initial order and that facility managers monitor compliance.

Concur

Target date for completion: February 1, 2016

Facility Response: The Respiratory Therapist (RT) who coordinates the home oxygen program will track the evaluation/re-evaluation process and notify the appropriate PACT team of needed follow up. The PACT nurse will complete walking pulse oximetry between days 60 and 70. The RT will forward outliers the provider by day 80 for review and renewal or discontinuation of home oxygen. Monitoring will be completed by RT, and will be reported to Clinical Practice Council until 90 percent compliance is sustained for three months.

Office of Inspector General
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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.
- VHA Directive 2011-036, *Safety and Health During Construction*, September 22, 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 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[h] References used for this topic included:
- VHA Directive 2006-021, *Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected*, May 1, 2006.
- VHA Handbook 1173.13, *Home Respiratory Care Program*, November 1, 2000.