Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00606-495

Combined Assessment Program Review of the Battle Creek VA Medical Center Battle Creek, Michigan

August 31, 2015

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Battle Creek 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 June 22, 2015.

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

- Advance Directives

The facility's reported accomplishment was receiving the Joint Commission's Top Performer on Key Quality Measures® award in hospital-based inpatient psychiatric services core performance measures for 2013.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure credentialing and privileging folders do not contain non-allowed information.

Environment of Care: Ensure patient care areas are clean. Secure medication carts when not in use. Maintain auditory privacy in all intake/exam areas.

Medication Management: Check emergency crash carts with the frequency required by local policy.

Coordination of Care: Ensure requestors consistently select the proper consult title.

Computed Tomography Radiation Monitoring: Revise the Radiology Service computed tomography quality assurance guideline to include radiologist review of appropriateness of computed tomography orders and specification of protocol prior to scans.

Emergency Airway Management: Comply with Veterans Health Administration requirements for emergency airway management.

Comments

The Acting Veterans Integrated Service Network and Facility Directors concurred with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–28, 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:

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

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

The review covered facility operations for FY 2014 and FY 2015 through June 25, 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 Battle Creek VA Medical Center, Battle Creek, Michigan,* Report No. 12-04188-140, March 21, 2013).

During this review, we presented crime awareness briefings for 118 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 613 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

Joint Commission Award

The Joint Commission recognized the facility with the Top Performer on Key Quality Measures® award in hospital-based inpatient psychiatric services core performance measures for 2013. The core performance measures included the following:

- Admission screening for violence risk
- Substance use
- Psychological trauma history and patient strengths
- Patients discharged on multiple antipsychotic medications
- Documentation of continuing care plan with transmission to next level of care provider upon discharge

To receive the award, hospitals much achieve a rate of 95 percent on every applicable reported accountability measure for 12 calendar months.

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

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key 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.	• All 10 folders contained non-allowed information, including performance data, training records, and committee meeting minutes.	**1.** We recommended that facility managers ensure that credentialing and privileging folders do not contain non-allowed information.
	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.		
	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.		

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.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	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 retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected two acute inpatient units (medical and MH/geriatric), a community living center unit, two specialty clinics (men's health and cardiology), 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
X	The facility met environmental safety requirements.	• One of the six patient care areas had dirty chairs in the patient waiting area. • Two of the six patient care areas needed high dusting. • One of the six patient care areas had dirty window coverings.	**2.** We recommended that facility managers ensure patient care areas are clean and monitor compliance.
	The facility met infection prevention requirements.		
X	The facility met medication safety and security requirements.	• A medication cart in one of the six patient care areas had an open, unlocked, and unattended drawer containing multiple medications.	**3.** We recommended that employees secure medication carts when not in use and that facility managers monitor compliance.
X	The facility met privacy requirements.	• Intake/exam areas in one of the six patient care areas did not have sufficient auditory privacy.	**4.** We recommended that facility managers maintain auditory privacy in all intake/exam areas and monitor compliance.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	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.		

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

Medication Management

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

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the MH and acute medical units, a community living center unit, and the 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. 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
	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.		
X	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.	• Two emergency crash carts did not consistently receive daily checks as required by local policy.	**5.** We recommended that facility managers ensure emergency crash carts receive checks with the frequency required by local policy and monitor compliance.
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
NA	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.		
	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 26 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.	• Six consult requests did not include "inpatient" in the title.	**6.** We recommended that requestors consistently select the proper consult title 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 four 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 Radiology Service CT quality assurance guideline did not include radiologist review of appropriateness of CT orders and specification of protocol prior to scans.	**7.** We recommended that facility managers revise the Radiology Service computed tomography quality assurance guideline to include radiologist review of appropriateness of computed tomography orders and specification of protocol prior to scans.

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

ADs

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

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 47 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 the EAM coverage schedule for 30 selected dates from January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a local EAM policy or had a documented exemption.	• Although the facility believed it had an exemption to the VHA directive, for the selected dates January–June 2014, it used VA paramedic employees for EAM coverage. o None of the responders had all required competency assessment components. o The facility did not have a local EAM policy. o Although the facility had other devices for airway management, it did not have video laryngoscopes available for emergent use.	**8.** We recommended that facility managers comply with Veterans Health Administration directive requirements for exempted facilities, or if facility managers plan emergency intubation responses with onsite employees, they comply with Veterans Health Administration requirements for non-exempted facilities.
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.		
NA	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		

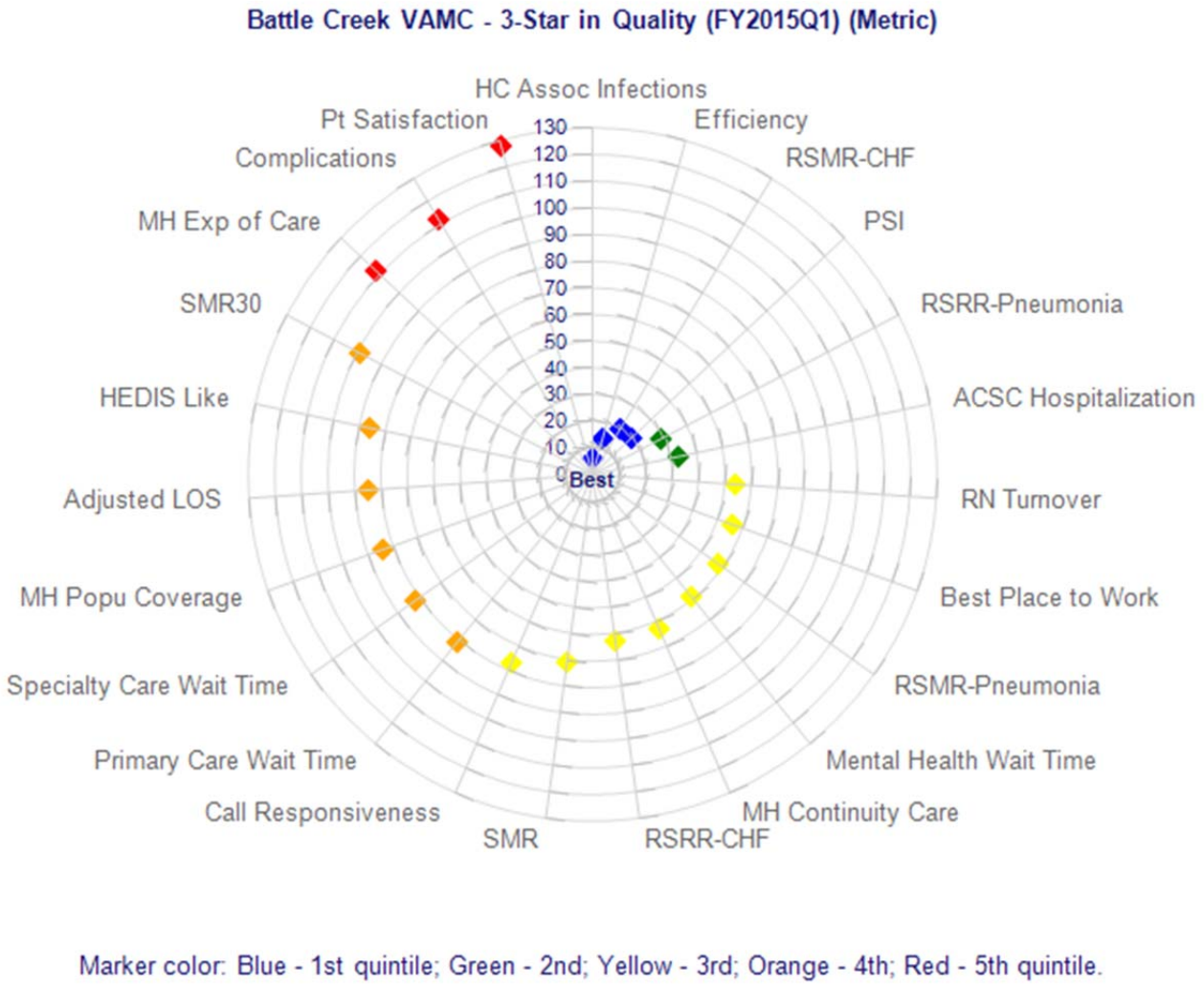
NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment 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		
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		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	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.		
NA	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
NA	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Battle Creek/515) FY 2015 through June 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$245.6
Number of:	
• **Unique Patients**	38,282
• **Outpatient Visits**	474,181
• **Unique Employees**[2]	1,272
Type and Number of Operating Beds (as of May 2015):	
• **Hospital**	66
• **Community Living Center**	109
• **MH**	92
Average Daily Census (as of May 2015):	
• **Hospital**	53
• **Community Living Center**	74
• **MH**	79
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Grand Rapids/515BY Muskegon/515GA Lansing/515GB Benton Harbor/515GC
Veterans Integrated Service Network Number	11

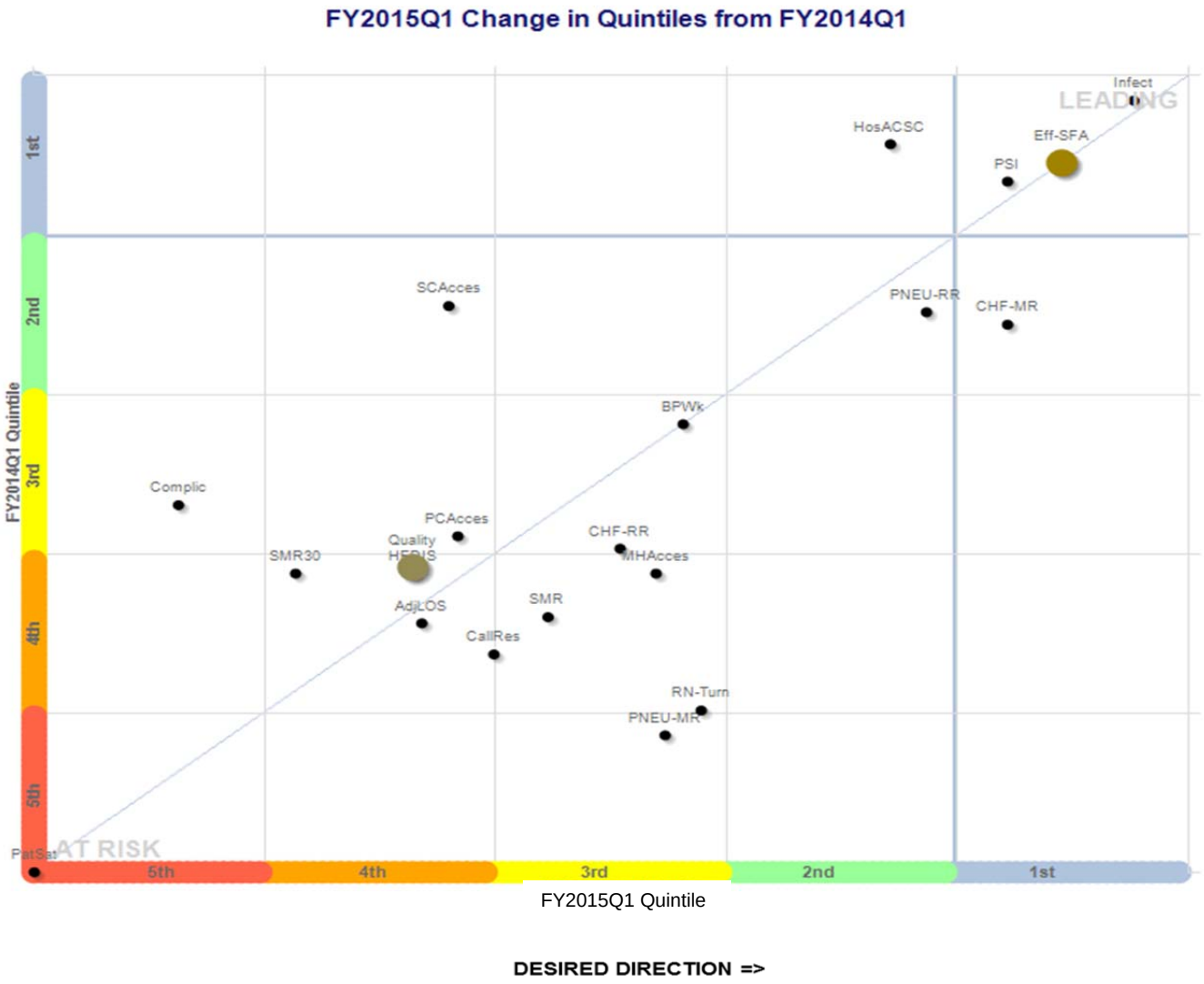
[1] All data is for FY 2015 through June 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: August 4, 2015

From: Acting Director, Veterans in Partnership (10N11)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

1. Please find attached response addressing the CAP Review conducted at the Battle Creek VA Medical Center located in Battle Creek, MI.

2. If you have any questions, please contact Carol M. Jones, RN, Chief Quality Safety & Values/Chief Nurse Officer at 734-222-4300.

(*original signed by*:)
ROBERT P. McDIVITT, FACHE/VHA-CM

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: August 5, 2015

From: Director, Battle Creek VA Medical Center (515/00)

Subject: **CAP Review of the Battle Creek VA Medical Center, Battle Creek, MI**

To: Acting Director, Veterans in Partnership (10N11)

I have reviewed and concur with the action plans regarding the Combined Assessment Program (CAP) review conducted at the Battle Creek VA Medical Center, Battle Creek, MI.

Sincerely,

Mary Beth Skupien

MARY BETH SKUPIEN, Ph.D.

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 credentialing and privileging folders do not contain non-allowed information.

Concur

Target date for completion: October 31, 2015

Facility response: All non-allowed information will be removed from all 275 credentialing and privileging files.

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

Concur

Target date for completion: September 30, 2015

Facility response: The Building 2, Radiology Waiting Area chairs were steam cleaned on June 26, 2015, removing the stains. High dusting was completed in Building 84, Community Living Center on June 25, 2015. Attempts to clean the window coverings in Building 84, Community Living Center were unsuccessful, requiring their replacement which was completed on July 31, 2015. Sustained improvement will be monitored by the Environmental Management Section through their monthly EMS Supervisor inspections; as well as, the weekly Environment of Care (EOC) Rounds Program. Results will be reviewed monthly during the Medical Center's Safety Committee.

Recommendation 3. We recommended that employees secure medication carts when not in use and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2015

Facility response: Inpatient Mental Health Medication Nurses will check to ensure all drawers are securely locked on the medication cart following each opening of the cart. Nurse Mangers will conduct random checks on each medication cart weekly until 100% compliance has been achieved for a 90 day period.

Recommendation 4. We recommended that facility managers maintain auditory privacy in all intake/exam areas and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Building 2, Room 226 (Radiology Stress Lab) is constructed to VA design standards including a solid core door to limit noise transmission. The room is located in the Radiology exam suite with limited traffic, and away from the main waiting room. A white noise machine was installed in the room to assist with masking any conversations. Staff was re-educated to ensure they are protecting the auditory privacy of our Veterans. Compliance will be monitored through the Environment of Care (EOC) Rounds Program.

Recommendation 5. We recommended that facility managers ensure emergency crash carts receive checks with the frequency required by local policy and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: MCM 11-1160 Medical Emergency Policy has been updated with current check sheets and specific directions to check the carts every 24 hours. All crash cart checklists will be monitored weekly by the Nursing Officer of the Day (NOD) until there is 100% compliance with crash cart checks for four weeks. The crash cart checklists will then be checked monthly by the NOD to ensure continued compliance.

Recommendation 6. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: All Licensed Independent Practitioners completed nationally developed and assigned consult management training module in the Talent Management System during the month of July. Staff who have made these errors have been individually educated and reminded of the consult business rules for ordering consults with the correct consult title.

Consult reports are run on a monthly basis, at a minimum, and feedback is provided to staff when the incorrect title is inadvertently selected. Through the HAS/Clinical supervisory chain, schedulers and consult managers have been reminded they can and should forward any incorrectly selected consults to the correct inpatient or outpatient consult title.

The Consult Committee will extract and compile monthly data snapshots of outpatient consults ordered for inpatient services and report the data in monthly meeting minutes along with any follow up actions associated with the findings.

Recommendation 7. We recommended that facility managers revise the Radiology Service computed tomography quality assurance guideline to include radiologist review of appropriateness of computed tomography orders and specification of protocol prior to scans.

Concur

Target date for completion: December 30, 2015

Facility response: The facility Managers will update Radiology Service computed tomography quality assurance guideline to include radiologist review of appropriateness of computed tomography orders and specification of protocol prior to scans by September 30, 2015. Chief of Staff or designee will monitor for compliance and sustained improvement for three months.

Recommendation 8. We recommended that facility managers comply with Veterans Health Administration directive requirements for exempted facilities, or if facility managers plan emergency intubation responses with onsite employees, they comply with Veterans Health Administration requirements for non-exempted facilities.

Concur

Target date for completion: September 30, 2015

Facility response: The Battle Creek VA Medical Center previously had a waiver under the Out of OR Airway Management Requirements VHA Directive 2012-032. Full compliance with the current directive is being completed through the training and utilization of station Paramedics. Paramedic training, including the completion of a TMS module, live intubations, and video laryngoscopes; along with updates to the station policy will be completed on or before September 30, 2015.

Office of Inspector General
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Endnotes

[a] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
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- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
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- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
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- 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.
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- 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.
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[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:
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- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
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[f] The references used for this topic included:
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[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.