



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

Office of Healthcare Inspections

Report No. 15-04641-304

Healthcare Inspection

Quality of Care and Other Concerns Robert J. Dole VA Medical Center Wichita, Kansas

July 19, 2017

Washington, DC 20420

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Table of Contents

	Page
Executive Summary	i
Purpose	1
Background	1
Scope and Methodology	3
Inspection Results	5
Issue 1 Patient Mortality.....	5
Issue 2 Facility Actions	6
Issue 3 Quality of Care	7
Issue 4 Intensive Care Unit Care During Off-Hours	7
Issue 5 Intensive Care Unit Transfers to Community Hospitals	8
Issue 6 Other Issues Identified	8
Conclusions	9
Recommendations	11
Appendixes	
A. Veterans Integrated Service Network Director Comments	12
B. Facility Director Comments.....	13
C. Office of Inspector General Contact and Staff Acknowledgments	16
D. Report Distribution.....	17

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Robert J. Dole VA Medical Center (facility) in Wichita, KS, in response to a July 15, 2015 request from former Congressmen Tim Huelskamp and Mike Pompeo.

In a letter, Congressmen Huelskamp and Pompeo requested that we:

- Determine if the facility had a higher mortality rate than other similar VA hospitals for patients transferred from the inpatient medical/surgical unit to the intensive care unit (ICU).
- Determine when facility leaders identified any problems with the mortality rate and what actions facility managers took to remedy the situation.
- Determine if any veterans died prematurely or had a lower quality of life due to inadequate or inattentive medical staff and whether a doctor was playing video games instead of taking care of patients.
- Determine who was responsible for the care of patients when they were transferred to the ICU during off-hours, whether doctors were required to report to the hospital during off-hours if an emergency arose, and if so, how often had this occurred.
- Determine if there had been any incidents of patients transferred to a local (non-VA) community hospital after transfer to the facility's ICU and if so, why.

The Inpatient Evaluation Center (IPEC) is a VA program that measures and reports VHA facilities' quarterly mortality data.¹ IPEC uses metrics to estimate expected patient mortality, which includes factors such as age, diagnosis/procedure, and comorbid medical conditions. VHA requires that managers review IPEC mortality data and take action when negative trends are identified.² In this report, we reviewed and discussed aggregate IPEC WardUM30³ data. Specific IPEC data are considered confidential under 38 U.S.C §5705.⁴

¹ IPEC Website, <http://vaww.va.gov/ipec/>. Accessed July 21, 2016. This is an internal VA website, which is not available for public viewing.

² Deputy of Quality Management in VHA for Operations and Management Memorandum, *Evaluation of Quality Management in VHA Facilities FY2010*, February 23, 2011, Item 5.

³ WardUM30 is the risk unadjusted mortality rate for patients transferred from wards to the ICU. WardUM30 measures the percentage of patients transferred from a ward to an ICU who die within 30 days of admission and includes patients who were discharged from the facility after transfer to the ICU. This is out of the total number of patients transferred to the ICU from the ward. The facility's WardUM30 percentages are compared to similar VA facilities with similar ICUs over a specific timeframe. IPEC reports use a red font to indicate outlier data, such as a higher mortality rate (95th percentile).

⁴ VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008. Focused Reviews (including Inpatient Evaluation Center (IPEC))...which address specific issues (usually of major consequences to patient care processes and outcomes) or specific incidents (usually involving a discrete episode of care), and which are designated by the responsible office at the outset of the review as protected by 38 U.S.C. 5705, and its implementing regulations, are considered confidential.

The facility's mortality data available at the time of the congressional request (April through June 2015) did not indicate the mortality rate for patients transferred from the medical/surgical unit to the ICU (WardUM30) was higher than other similar VHA facilities at any time during fiscal year (FY) 2015. Nor did the FY 2015 data indicate the facility was in the 95th percentile (higher mortality) of like facilities. However, the facility's WardUM30 mortality data for 1 quarter in FY 2014 was higher than other similar VHA facilities with outliers ranking in the 95th percentile of like or similar VA facilities. Facility leaders were notified the following quarter of the increase in the WardUM30 mortality rate, and Veterans Integrated Service Network staff requested an action plan. Within a month, facility staff took action.

We reviewed the quality of care provided by facility staff to 28 patients who received care in the medical/surgical unit and ICU during the time frame at issue. We did not find evidence of inadequate or inattentive care. These patients were admitted with complex medical conditions such as metastatic cancer, septic shock, and severe heart disease. Providers documented treatment choices that reflected patients' or patient families' wishes for end of life care. Overall, the electronic health records contained documented analyses of the diseases, rationale for particular regimens used, and adjustments made to the treatment plans. However, we learned that facility leaders had disbanded the Palliative Care Consult Team that provided patients with end-of-life care and services in 2014,^{5,6} which was not in compliance with VHA and facility policy.

During our July 2015 unannounced site visit, we found one physician working as the nocturnist (providers who work the night shift) and two medical residents, available to care for ICU patients. Additionally, tele-ICU services were available. We did not observe indications that doctors were playing video games and individuals we interviewed denied that they had done so.

Facility procedures required anesthesiology and surgery staff to return to the facility during off-hours within a specific timeframe, as needed for patient care. For other attending physicians, facility policy was not as well-defined. We were unable to determine how often physicians returned to the facility during off-hours. Facility staff did not document physicians' return to the facility, and were not required to track such data by facility policy. At the time of our review, facility staff stated there were no reported cases where physicians refused to return to the facility during off-hours for care of ICU patients.

During the first 2 quarters of 2015, facility staff transferred 4 patients to local community hospitals out of 668 ICU admissions. The transfers were for medical services not available at the facility, and we found these transfers were justified. Facility transfer policy designates staff to coordinate and track patients in non-VA community care.

⁵ VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008. This directive expired October 31, 2013 and has not yet been updated.

⁶ Robert J. Dole VA Medical Center Circular CPC-12-22.

We found system deficiencies in VHA and facility policy compliance and identified a nocturnist coverage concern. Facility staff reported that the Emergency Department (ED) provider would leave the ED to perform intubations when mid-level providers, who could not perform emergency intubation, worked as nocturnists. We confirmed this practice when we reviewed one of the EHRs, which documented the ED provider performed an intubation outside of the ED.

During our site visit in 2015, a physician was providing nocturnist services; however, mid-level providers, who were not authorized to perform emergency airway intubation, could also be scheduled as nocturnists. Leaders reported to us the practice of using mid-level providers for the role of nocturnists was discontinued August 1, 2015, and they planned to have only physician nocturnists.

We made the following recommendations to the Facility Director:

- Implement applicable recommendations from previous event-related reviews and monitor compliance.
- Ensure that processes are strengthened for the Hospice and Palliative Care Program and that appropriate designated staff are assigned to the Palliative Care Consult Team to adhere to Veterans Health Administration and facility policy.
- Assess the need to define the required timeframe for attending physicians to return to the facility if needed for patient emergencies.
- Ensure compliance with facility policy for clinicians designated to perform emergency airway management.
- Ensure compliance with Veterans Health Administration policies on Emergency Department coverage.
- Ensure the continued practice of physician only coverage for the role of nocturnist.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 12–15 for the Directors' comments.) We consider Recommendations 1, 2, 4, 5, and 6 closed. We will follow up on the planned action for the remaining recommendation until completed.



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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a July 2015 request from former Congressmen Tim Huelskamp and Mike Pompeo to review the mortality rate of patients transferred to the intensive care unit (ICU) and other quality of care concerns at the Robert J. Dole VA Medical Center (facility) in Wichita, KS.

Background

Facility Profile. This 81-bed facility is located in Wichita, KS, and is part of Veterans Integrated Service Network (VISN) 15. As a teaching hospital, the facility has an academic affiliation with a medical school residency program and offers a broad range of inpatient and outpatient health care services in primary, specialty, behavioral health, and extended care. Inpatient services include an 8-bed, Level 2, mixed ICU;⁷ a medical/surgical unit; and a Community Living Center. The facility serves more than 30,000 veterans in 59 counties in Kansas.

Inpatient Evaluation Center. The Inpatient Evaluation Center (IPEC) is a Veterans Health Administration (VHA) program that includes processes and metrics that help facilities identify opportunities for improving patient outcomes in acute care including ICU.⁸ IPEC uses metrics to estimate expected mortality, which includes factors such as age, diagnosis/procedure, comorbid medical conditions, and other factors. IPEC also has general exclusion criteria where patients are not included in the metrics, such as patients who have died within 4 hours of hospital admission and patients who received hospice care within 1 year prior to or on the same day of admission.

IPEC provides quarterly mortality data reports, called the Brief Analytic Report (BAR), on each VHA medical center the quarter after a data collection period is complete.⁹ IPEC reports are generally available for review towards the end of the quarter following the data collection period, and VHA requires that managers review IPEC mortality data and take action when negative trends are identified. The data are also available to VISN leaders. In this report, we reviewed IPEC WardUM30 data.

WardUM30.¹⁰ WardUM30 is the percentage of observed deaths in patients transferred from an acute care ward to the ICU and includes patients who have been discharged

⁷ VHA has defined ICU criteria that establishes the level of care from Highly Complex (level 1) to Basic (level 4). Additionally, VHA designates the ICU by types of specific clinical care offered such as Medical Intensive Care Unit, Surgical Intensive Care Unit, Coronary Care Unit, and Mixed. Mixed ICUs can provide a variety of services to include both medical and surgical care.

⁸ IPEC mortality metrics guidelines, <http://vaww.va.gov/ipecc/>. Accessed July 28, 2015. This is an internal VA website, which is not available for public viewing.

⁹ The BAR is a quarterly report that contains a variety of VA facility data and information including the WardUM30. IPEC website, <http://vaww.va.gov/ipecc/>. Accessed July 28, 2015.

¹⁰ The risk unadjusted WardUM30 percentage numerator is the number of observed deaths in patients transferred to the ICU from the ward, and the denominator is the total number of patients transferred to the ICU from the ward.

from the facility and died within 30 days of admission. WardUM30 data may be used in conjunction with other IPEC mortality data as an indicator of the hospital's ability to detect and rescue deteriorating patients.

Mortality Data Analysis. When observed mortality rates exceed expected mortality rates, the discrepancy provides an opportunity to review processes and determine if care deficiencies exist. However, deaths may be unexpected but have no relationship to a quality of care failure. For example, patients who experience serious illness may be hospitalized and request palliative (comfort-only) or hospice care on admission or during their hospitalization. Consequently, while higher mortality rates require further investigation, the higher rate may not be evidence of poor quality of care.

Allegations. In a letter dated July 15, 2015, former Congressmen Tim Huelskamp and Mike Pompeo requested that we:

- Determine if the facility had a higher mortality rate than other similar VA hospitals for patients transferred from the inpatient medical/surgical unit to the ICU.
- Determine when facility leaders identified any problems with the mortality rate and what actions facility managers took to remedy the situation.
- Determine if any veterans died prematurely or had a lower quality of life due to inadequate or inattentive medical staff and whether a doctor was playing video games instead of taking care of patients.
- Determine who was responsible for the care of patients when they were transferred to the ICU during off-hours,¹¹ whether doctors were required to report to the hospital during off-hours if an emergency arose, and if so, how often had this occurred.
- Determine if there had been any incidents of patients transferred to a local (non-VA) community hospital after transfer to the facility's ICU and if so, why.

¹¹ For this report, we considered off-hours as off-duty hours, which are hours outside the timeframe of 8:00 a.m.–4:30 p.m., Monday–Friday.

Scope and Methodology

We conducted our review from July 2015 through February 2016. We obtained additional follow-up documents in October 2016.

We made an unannounced site visit at the facility from July 21 through July 23, 2015. On August 4, 2015, we also made a site visit to the VISN 15 office and interviewed the VISN 15 Quality Management Officer (QMO).

We interviewed the facility's Director; Deputy Chief of Staff (COS) and Director of ICU Specialty Care/Acting COS; Emergency Department (ED) Director; Chief of QM; QM Risk Manager; QM Survey Coordinator; Patient Safety Manager; Associate Director Patient Care Service Nurse Executive; Chief of Social Work; ED Physician; Nocturnist (night-time) Staff Physician; Junior Resident; Program Analyst; Nurse Managers in ED, ICU, and Medical/Surgical unit; nursing staff; Transfer Coordinator; and IPEC program analyst.

We reviewed VHA and facility administrative documents, policies and procedures, QM documents, and other relevant documents. We also reviewed FY 2014 and FY 2015 IPEC data and documents.

We identified and reviewed the electronic health records (EHR) for 32 patients (28 inpatients and 4 transfers). To answer the question concerning whether veterans died prematurely or had a lower quality of life, we reviewed the documentation in the EHRs of 28 of the 32 identified patients to determine if facility staff intervened appropriately to address the patients' medical conditions and whether harm occurred that hastened death or lowered patients' quality of life.

Three VHA policies cited in this report were expired or beyond the recertification date:

1. VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008 (expired October 31, 2013).
2. VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008 (expired November 30, 2013).
3. VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010 (recertification due August 31, 2015).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),¹² the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a

¹² VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

more recent policy or guidance.”¹³ The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring “...the timely rescission or recertification of policy documents over which their program offices have primary responsibility.”¹⁴

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

¹³ VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document*, June 29, 2016.

¹⁴ Ibid.

Inspection Results

Specific IPEC data is considered confidential under 38 U.S.C §5705¹⁵ and is, therefore, not discussed in this report.

Issue 1: Patient Mortality

Mortality Data

We found that the mortality rate for patients transferred from the inpatient medical/surgical unit to the ICU (WardUM30) was not higher than other similar VA hospitals at the time of the July 15, 2015 congressional inquiry. Additionally, IPEC staff did not identify the facility's WardUM30 data as higher mortality (95th percentile) among like VA facilities for any FY 2015 quarter. Consequently, no problem existed for facility leaders to identify or remedy for FY 2015.

For FY 2014, however, we found the facility had a higher than expected mortality rate during one quarter and focused our review on that timeframe.

OIG Case Reviews

We reviewed the EHRs of the patients at issue for the quarter in FY 2014 with mortality data higher than other VA hospitals that placed the facility in the 95th percentile of like facilities. In this quarter, six patients who were transferred to the ICU from the acute care unit within the facility died within 30 days of admission. We did not find quality of care issues or concerns.

These patients were admitted with complex medical conditions such as metastatic cancer, septic shock, and severe heart disease; four of the six patients had hospice consults or were receiving hospice care. Providers documented treatment choices that reflected patients' or patients' family's wishes for end of life care. Overall, the EHRs contained documented analyses of the diseases, rationale for particular regimens used, and adjustments made to the treatment plans.

Hospice and Palliative Care

Hospice and Palliative Care (HPC) services are offered to patients who are facing end-of-life or an advanced, life-limiting terminal diagnosis seeking comfort care

¹⁵ VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents*, November 7, 2008. Focused Reviews (including Inpatient Evaluation Center (IPEC)...which address specific issues (usually of major consequences to patient care processes and outcomes) or specific incidents (usually involving a discrete episode of care), and which are designated by the responsible office at the outset of the review as protected by 38 U.S.C. 5705, and its implementing regulations, are considered confidential. This Directive expired November 2013 and has not yet been updated.

treatment with a life expectancy of 6 months or less.¹⁶ VA facilities, through coordinated services, provide relief of patients' symptoms through a palliative care program. HPC services provide a means of focusing on maintaining a patient's quality of life through support services that include specialists, home, office, or telephone visits, and accessing community resources. As disease states progress, palliative care services will often lead to hospice care services that provide end-of-life care for those patients who have less than 6 months to live.

VHA and facility policy requires that the facility have a Palliative Care Consult Team (PCCT).^{17,18} The PCCT is a multidisciplinary team that includes a physician, nurse, social worker, dietitian, and pastor who assist in education, evaluation, and coordination of care for comfort and supportive services. PCCT involvement ensures that the education, continuum of care, and wishes of the HPC¹⁹ patient are addressed in a timely manner.^{20,21} The PCCT provides feedback to the primary care provider about the patient's ability to carry out day-to-day activities with comfort.

Most of the 28 patients did not have an HPC care designation but may have been appropriate for this service. On hospital admission, in the absence of this designation, patients were admitted to the ICU instead of HPC services. Patients we reviewed were well advanced in their disease states and may have qualified for palliative or hospice services. We learned that facility leaders disbanded the PCCT in February 2014,^{22,23} which was not in compliance with VHA and facility policy.^{24,25} Absence of a PCCT during FY 2014 was not consistent with VHA and facility policy and may have influenced the higher mortality rate. The facility leaders reinstated the PCCT in April 2015.

Issue 2: Facility Actions

When Facility Leaders Became Aware

In 2014, the VISN QMO sent an email to the facility about the data that was higher than other similar VA hospitals approximately 10 weeks after the quarter at issue and requested an action plan. Facility leaders initiated reviews to determine if the higher mortality rate could be linked to quality of care concerns and submitted the action plan to the VISN.

¹⁶ Robert J. Dole VA Medical Center Circular CPC-12-22, *Hospice and Palliative Care (HPC) Program*, June 21, 2012. This facility policy was scheduled for recertification June 21, 2015, and a new policy was issued on December 15, 2015.

¹⁷ VHA Directive 2008-066, *Palliative Care Consult Teams (PCCT)*, October 23, 2008. This VHA Directive expired October 31, 2013 and has not yet been updated.

¹⁸ Robert J. Dole VA Medical Center Circular CPC-12-22.

¹⁹ As HPC patients' disease states progress, palliative care services will often lead to hospice care services that provide end-of-life care for those patients who have less than 6 months to live.

²⁰ VHA Directive 2008-066.

²¹ Robert J. Dole VA Medical Center Circular CPC-12-22.

²² VHA Directive 2008-066,

²³ Robert J. Dole VA Medical Center Circular CPC-12-22.

²⁴ VHA Directive 2008-066.

²⁵ Robert J. Dole VA Medical Center Circular CPC-12-22.

Facility Actions

During interviews, staff outlined the following actions that were taken.

- Review of data
- Re-starting the Hospice team
- Hiring of physicians for nocturnist coverage
- Having a follow-up clinic for discharged patients
- Review of coding

In July 2015, during our onsite review, corrective actions were ongoing. In October 2016, we contacted facility staff to confirm that actions were being implemented and monitored.

Issue 3: Quality of Care

Premature Death and Lower Quality of Life

We did not find that patients died prematurely or had a lower quality of life due to inadequate or inattentive medical staff. Twenty-eight patients died while receiving care in the medical/surgical unit and ICU or within 30 days of admission during the time frame at issue in FY 2014. We reviewed all 28 patients who died; 6 of these patients were discussed in Issue 1. Of the remaining 22 patients, we did not find quality of care issues or concerns. Providers documented treatment choices that reflected patients' or patients' family's wishes for end of life care. Overall, the EHRs contained documented analyses of the diseases, rationale for particular regimens used, and adjustments made to the treatment plans.

Doctor Playing Video Games

We did not observe doctors playing video games instead of taking care of patients during our unannounced site visit on the evening of July 21, 2015. We inspected physician work rooms and did not find evidence of video game equipment. Staff we interviewed did not report to us that they were aware of or had observed physicians playing video games, and facility managers had no reported incidents of physicians playing video games.

Issue 4: ICU Care during Off-Hours

Responsibility for ICU Care During Off-Hours

During our unannounced site visit on the evening of July 21, 2015, we found one physician nocturnist (providers who work the night shift) and two medical residents available to care for ICU patients. Additionally, tele-ICU services were available.

Staff Reporting to the Facility for Emergencies

Facility procedures required anesthesiology staff to return within 30 minutes and surgeons to return to the facility within 60 minutes, as needed for patient care.²⁶ For other staff providers, facility policy states that the attending physician responsible for resident supervision must be immediately available to the resident in person or by telephone.²⁷ The attending “physician must be able to be present in person within a reasonable period of time if necessary.”²⁸ In life-threatening emergencies, in which residents begin emergency procedures, the attending physician must come in to see patients and write notes in the EHRs as soon as possible. The facility policy also requires that attending physicians be immediately available should patients’ conditions worsen.²⁹

During interviews, the acting COS informed us that the general expectation for ICU attending physicians was to return to the facility as soon as possible if needed, but could not provide a defined, exact timeframe.

We were unable to determine how often physicians returned to the facility during off-hours. Facility managers did not document when physicians returned, and they were not required to track such data by facility procedures. At the time of our review, facility staff stated there were no cases in which physicians refused to return to the facility during off-hours to care for patients in the ICU.

Issue 5: ICU Transfers to Community Hospitals

During the first 2 quarters of FY 2015, facility staff transferred 4 patients to local community hospitals out of 668 ICU admissions. The transfers were for medical services not available at the facility, and we found the transfers were justified. A facility policy governs interfacility transfers and designated staff coordinate and track patients while in non-facility hospitals/community care.³⁰

Issue 6: Other Issues Identified

While not part of the complaint letter, we found system deficiencies in VHA and facility policy compliance and identified a nocturnist coverage concern.

²⁶ Robert J. Dole VA Medical Center Surgery Standard Operating Procedure, *Anesthesia Coverage*, March 27, 2014 with review on March 27, 2015.

²⁷ VHA resident programs ensure training of future health care professionals through appropriate clinical supervision of residents by attending physicians. VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

²⁸ Robert J. Dole VA Medical Center Circular CPC-14-13, *Monitoring of Resident Supervision*, February 19, 2014.

²⁹ Ibid.

³⁰ Robert J. Dole VA Medical Center Circular CPC-13-33, *External Care Policy, Inpatient Transfers and Unplanned Admissions*, June 21, 2013.

Emergency Airway Management

VHA Handbook 1101.04 requires that a qualified physician be present in the ED at all times who is not to be responsible for any inpatient activities except under certain conditions which were not applicable to this facility.³¹ Additionally, the facility emergency airway management policy stated that the nocturnist is responsible for managing a patient's airway during an emergency, which may include intubation.³²

At the time of our site visit, physicians and mid-level providers could be scheduled as nocturnists.³³ Facility staff reported that the ED provider would leave the ED to perform intubations when mid-level providers, who could not perform emergency intubation, worked as nocturnists. We confirmed this practice when we reviewed one of the EHRs, which documented the ED provider performed an intubation outside of the ED.

Nocturnist Coverage

We requested that facility leaders immediately discontinue the use of mid-level providers in the role of nocturnists and assign only physicians to that particular role. Facility leaders took immediate action to comply with our request. The practice was formally discontinued on August 1, 2015. In May 2016, we confirmed that only physicians were assigned to the nocturnist role.

Conclusions

The facility's mortality data available at the time of the congressional request did not indicate the mortality rate for patients transferred from the medical/surgical unit to the ICU (WardUM30) was higher than other similar VHA facilities at any time during FY 2015. However, we found the facility did not meet FY 2014 national VHA mortality rate benchmarks.

We reviewed the quality of care provided to the 28 patients who died while receiving care in the medical/surgical unit and ICU or within 30 days of admission during the time frame at issue FY 2014. We did not find evidence of inadequate or inattentive care. However, we found that the lack of a PCCT was not consistent with VHA and facility policy and may have influenced the higher mortality rate. Most of the 28 patients did not have an HPC care designation but may have been appropriate for this service. On hospital admission, in the absence of this designation, patients were admitted to the ICU instead of HPC services.

³¹ VHA Handbook 1101.04.

³² Robert J. Dole VA Medical Center Circular CPC-13-17, *Out of Operating Room Airway Management*, March 27, 2013. This local policy was scheduled for rescission March 27, 2016 but has not yet been replaced.

³³ A mid-level provider is a licensed clinical medical professional, such as a nurse practitioner or physician assistant, who provides patient care under a scope of practice, which must include the degree of physician supervision required. The facility by-laws generally govern the practice and requirements of mid-level providers. VHA Directive 1063, *PA Scope of Practice and Competency Assessments*, December 24, 2013, Appendix A.

The VISN QMO sent an email to the facility about the higher than other similar VA hospital data approximately 10 weeks after the quarter at issue and requested an action plan. Facility staff described to us actions taken in response to the notification which included a review of the data and re-initiation of the Hospice team.

During our unannounced site visit on the evening of July 21, 2015, we did not observe doctors playing video games instead of taking care of patients. We found one physician nocturnist and two medical residents available to care for ICU patients. Additionally, tele-ICU services were available.³⁴

We found facility procedures required anesthesiology and surgery staff to return to the facility as needed for patient care in defined timeframes, while for other attending physicians, the facility policy was not as well-defined. We were unable to determine how often physicians returned to the facility during off-hours to care for patients. Facility managers did not document or track when physicians returned after hours, and it was not required by facility procedures. At the time of our review, facility staff stated there were no cases in which physicians refused to return to the facility during off-hours for care of ICU patients.

We reviewed patient transfers from the facility ICU to local community hospitals and found the transfers were for medical services not available at the facility, and we found the transfers were justified.

We found system deficiencies in VHA and facility policy compliance and identified a nocturnist coverage concern. Facility staff reported that the ED provider would leave the ED to perform intubations when mid-level providers, who could not perform emergency intubations, worked as nocturnists. We confirmed this practice when we reviewed one of the EHRs, which documented the ED provider performed an intubation outside of the ED.

At the time of our site visit, a physician was providing nocturnist services; however, mid-level providers, who were not authorized to perform emergency airway intubation, could also be scheduled. Facility leaders reported to us the practice of using mid-level providers for the role of nocturnists was discontinued and planned to have only physician nocturnists.

We made six recommendations.

³⁴ Tele-ICU is a process that electronically links a remotely-based ICU physician with the facility's direct patient care ICU staff. The remotely based ICU physician can do EHR reviews, consulting, prescribing, ordering tests, and other duties.

Recommendations

1. We recommended that the Facility Director implement applicable recommendations from previous event-related reviews and monitor compliance.
2. We recommended that the Facility Director ensure that processes are strengthened for the Hospice and Palliative Care Program and that appropriate designated staff are assigned to the Palliative Care Consult Team to adhere to Veterans Health Administration and facility policy.
3. We recommended that the Facility Director assess the need to define the required timeframe for attending physicians to return to the facility if needed for patient emergencies.
4. We recommended that the Facility Director ensure compliance with facility policy for clinicians designated to perform emergency airway management.
5. We recommended that the Facility Director ensure compliance with Veterans Health Administration policies on Emergency Department coverage.
6. We recommended that the Facility Director ensure the continued practice of physician only coverage for the role of nocturnist.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 29, 2017

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Quality of Care and Other Concerns, Robert J. Dole VA Medical Center, Wichita, Kansas

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Attached, please find response for the Healthcare Inspection—Quality of Care and Other Concerns, Robert J. Dole VA Medical Center, Wichita, Kansas.
2. I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused toward continuous performance improvement.
3. For additional questions please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at (816)-701-3000.



William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 17, 2017

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

Subj: Healthcare Inspection—Quality of Care and Other Concerns, Robert J. Dole VA Medical Center, Wichita, Kansas

To: Director, VA Heartland Network (10N15)

1. I have reviewed the findings and concur with the recommendations.
2. Attached are the corrective action plans with target completion dates.



Rick Ament, MSA, FACHE
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 the Facility Director implement applicable recommendations from previous event-related reviews and monitor compliance.

Concur

Target date for completion: Completed

Facility response: All recommendations from the previous event-related reviews have been implemented and compliance monitored.

Recommendation 2. We recommended that the Facility Director ensure that processes are strengthened for the Hospice and Palliative Care Program and that appropriate designated staff are assigned to the Palliative Care Consult Team to adhere to Veterans Health Administration and facility policy.

Concur

Target date for completion: Completed

Facility response: The hospice policy was revised on December 15, 2015 to include required membership and the Hospice Palliative Care Team (HPCT) membership now adheres to policy requirements.

Recommendation 3. We recommended that the Facility Director assess the need to define the required timeframe for attending physicians to return to the facility if needed for patient emergencies.

Concur

Target date for completion: June 30, 2017

Facility response: The nocturnist physician is in the facility at night and responds to patient emergencies. The practice for attending physicians is to return a phone call within 15 minutes and come back to the facility to evaluate the patient within 1 hour of notification if needed. The facility will add this into the bylaws by June 30, 2017.

Recommendation 4. We recommended that the Facility Director ensure compliance with facility policy for clinicians designated to perform emergency airway management.

Concur

Target date for completion: Completed

Facility response: The Out of Operating Room Airway Management (OOORAM) policy was revised on May 18, 2016 to specify that only trained, competent staff with current OOORAM privileges or scope of practice may perform emergency airway management. Trained OOORAM clinicians are available 24/7 and the facility adheres to the revised policy. The Chief of Anesthesia monitors compliance with the OOORAM policy and submits findings to the Critical Care Committee. Critical Care Committee minutes, which include OOORAM information, are reviewed by the Clinical Practice Council which is chaired by the Chief of Staff.

Recommendation 5. We recommended that the Facility Director ensure compliance with Veterans Health Administration policies on Emergency Department coverage.

Concur

Target date for completion: Completed

Facility response: The implementation for 24-hour physician hospitalist coverage was completed July 22, 2015. A scheduling audit verified that physician hospitalist coverage has been continuously in place since July 26, 2015. The Emergency Department (ED) physicians only provide coverage to the ED 24/7.

Recommendation 6. We recommended that the Facility Director ensure the continued practice of physician only coverage for the role of nocturnist.

Concur

Target date for completion: Completed

Facility response: Coverage for physician nocturnist has been implemented since July 22, 2015. A scheduling audit verified that physician hospitalist coverage has been continuously in place since July 26, 2015.

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