Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03742-73

Combined Assessment Program Review of the VA Eastern Kansas Health Care System Topeka, Kansas

January 25, 2010

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of November 16–20, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Eastern Kansas Health Care System (the system), Topeka, KS. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 187 system employees. The system is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Daily Access Reports.
- Identification of Fire Extinguishers on the Locked Mental Health (MH) Unit.

We made recommendations in five of the activities reviewed. For these activities, the system needed to ensure that:

- Staff cleanse and disinfect equipment between patient uses.
- Staff identified as at risk for exposure to a harmful atmosphere receive respirator fit testing, training, and medical evaluation, as required.
- All sharps containers are mounted within the required height range.
- Nurses consistently assess and document as needed (PRN) pain medication effectiveness within the timeframe specified by local policy.
- Pharmacists consistently perform and document monthly medication reviews on the community living center (CLC) units.
- Staff complete discharge documentation, as required by Veterans Health Administration (VHA) policy and Joint Commission (JC) standards.
- A designated, trained physician serves as an advisor for the utilization management (UM) program, as required by VHA policy.

- Contracted/agency registered nurses (RNs) have evidence of completed background investigations and clinical competence prior to providing patient care.

The system complied with selected standards in the following activity:

- Physician Credentialing and Privileging (C&P).

This report was prepared under the direction of Dorothy Duncan, Associate Director, and James Seitz, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–16, for full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system is comprised of two medical centers located in Leavenworth and Topeka, KS, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 10 community based outpatient clinics (CBOCs) in Chanute, Emporia, Fort Scott, Garnett, Holton, Kansas City, Lawrence, Junction City, and Seneca, KS, and in St. Joseph, MO. The system is part of VISN 15 and serves a veteran population of about 104,000 throughout 49 counties in Kansas and Missouri.

Programs. The system provides medical, surgical, MH, geriatric, and rehabilitation services. It has 197 hospital beds, 138 CLC beds, and 202 domiciliary beds. The system has sharing agreements with two military bases, the State of Kansas, and two community hospitals.

Affiliations and Research. The system is affiliated with the University of Kansas' School of Medicine and with the University of Missouri's School of Medicine and supports 33 medical resident positions. In fiscal year (FY) 2009, the system's research program had four projects and a budget of $11,450. Important areas of research included SELECT (Selenium and Vitamin E Cancer Prevention Trial), AVIDA (The Vidaza Patient Registry), Improving Long-Term Substance Use Disorders with Telephone Case Monitoring and Outcomes, and Trends in Addictions/Substance Use Disorder Clinical Data: A Ten Year Study Report.

Resources. In FY 2009, medical care expenditures totaled $238.8 million. The FY 2010 medical care budget has not yet been set. FY 2009 staffing was 1,822 full-time employee equivalents (FTE), including 93 physician and 545 nursing FTE.

Workload. In FY 2009, the system treated 35,047 unique patients and provided 48,349 inpatient days in the hospital and 27,639 inpatient days in the CLC units. The inpatient care workload totaled 4,232 discharges, and the average daily census, including CLC patients, was 209. Outpatient workload totaled 364,818 visits.

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 administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Physician C&P.
- QM.

The review covered system operations for FY 2009 and FY 2010 through November 19, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Leavenworth, Kansas,* Report No. 06-02820-141, June 15, 2007). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 187 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.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strengths

Daily Access Reports

In order to meet VHA's access performance measure, the system was spending a large amount of administrative time running individual reports with little improvement on the 30 day access list performance measure. In August 2009, the system implemented a new automatic daily reporting system that helped reduce the total number of veterans waiting more than 30 days for an appointment from 345 patients waiting on August 25, 2009, to 65 patients waiting on November 19, 2009. This automated report takes about 10–15 minutes to run and provides all clinics and service lines with a list of the patients waiting beyond 30 days. E-mail notifications are released each morning alerting providers to the total number of patients waiting beyond the 30 day timeframe. This automatic report process has reduced administrative work time from 6–8 hours a day to 10–15 minutes a day.

Identification of Fire Extinguishers on the Locked Mental Health Unit

On the locked MH unit, the ceiling tiles have been painted red to easily identify fire extinguisher locations. Conventional signage is a potential patient safety issue (suicide/hanging); therefore, the painting of ceiling tiles was initiated. Compared to flush mounted signs that can be difficult to locate, red ceiling tiles are visible from any hallway area.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether the system complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association, and JC requirements.

We conducted onsite inspections of the post-anesthesia care units; the locked MH unit; the emergency department; the radiology departments; outpatient clinic areas; and all inpatient medical/surgical, MH, intensive care, and CLC units. The system maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. System managers conducted quarterly MH EOC assessments for the locked MH unit and were pursuing corrective actions.

We identified three areas that needed improvement.

Infection Control. Local policy directs staff to cleanse and disinfect glucometers (blood sugar monitors) after using the devices in the rooms of patients on isolation precautions but does not address standard precautions for other patients. Observations and staff interviews revealed that licensed care staff did not follow standard precautions and contact isolation precautions during the performance of routine blood sugar testing. We interviewed six licensed care staff members—one from each of six separate inpatient units. Five of the six staff members indicated that they did not cleanse and disinfect glucometers shared between patients. Additionally, we observed a staff member placing a glucometer directly on a bedside table alongside personal care items in the room of a patient on contact isolation. The staff member did not cleanse or disinfect the glucometer before the next patient test.

Respirator Fit Testing. Local policy identified staff at risk for exposure, including employees who enter rooms isolated for tuberculosis and staff who work closely with suspected tuberculosis patients. To provide effective protection against

a harmful atmosphere, the system utilizes N95 respirators and powered air purifying respirators (PAPRs).[1] However, four (20 percent) of 20 selected direct care staff at risk for exposure did not receive the required fit testing, training, or medical evaluation for respirators.

Employee Safety. OSHA requires the tops of wall-mounted sharps containers (used for safe disposal of used needles and sharp objects) to be located 52–56 inches from the floor. Half of the sharps containers' tops were located above the 56-inch height limit.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that staff cleanse and disinfect equipment between patient uses.

The VISN and System Directors agreed with the findings and recommendation. System managers have completed written standard operating procedures (SOPs) for cleaning and disinfecting glucometers between patient uses. The SOPs are available to all staff. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive respirator fit testing, training, and medical evaluation, as required.

The VISN and System Directors agreed with the finding and recommendation. The system has implemented a coordinated process to provide identified staff with respirator fit testing, training, and medical evaluation. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires all sharps containers to be mounted within the required height range.

The VISN and System Directors agreed with the finding and recommendation. All sharps containers will be remounted at

[1] Respirators filter inspired air to help protect against microorganisms, including bacteria and many viruses. In health care settings, the most common type of respirator is a surgical N95 respirator. PAPRs protect workers against particulates by drawing ambient air through a high efficiency particulate air (HEPA) filter and supplying that air through a breathing tube into the hood and facepiece.

the appropriate height. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes in the intensive care, inpatient medical/surgical, MH, and CLC units.

We found that the system had a designated Bar Code Medication Administration Program coordinator who had appropriately identified and addressed problems. We identified two areas that needed improvement.

Documentation of Pain Medication Effectiveness. Local policy requires that nurses assess and document the effectiveness of PRN pain medications within 120 minutes after administration. We reviewed the medical records of 45 patients who received a total of 227 doses of pain medications. We found that only 130 (57 percent) of the 227 doses had effectiveness documented within the timeframe specified by local policy.

Monthly Medication Reviews. Accreditation standards require that a pharmacist review each CLC patient's medications monthly to identify any problems, such as interactions or duplications. On each of the three CLC units, we reviewed five patients' medication reviews for the last 12 months for a total of 60 required medication reviews per unit. We found that pharmacists completed all the monthly medication reviews on two of the three units. On the third unit, we found that only 37 (62 percent) of the required 60 monthly reviews were completed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that nurses consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

The VISN and System Directors agreed with the finding and recommendation. System managers are implementing a new program to improve PRN pain medication documentation. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that pharmacists consistently perform and document monthly medication reviews on the CLC units.

The VISN and System Directors agreed with the findings and recommendation. Pharmacists are now completing all monthly CLC medication reviews, and pharmacy supervisors are tracking compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to integrated care processes and optimal patient outcomes.

We found that staff generally managed intra-facility transfers and post-discharge MH care appropriately. We identified the following area that needed improvement.

Discharge Documentation. VHA policy requires specific information, such as diet and activity level, to be included in both the discharge summary and patient discharge instructions.[2] Additionally, JC standards require discharge summaries to be completed within 30 days after a patient's discharge. We reviewed the medical records of 42 discharged patients and found that 16 (38 percent) of the records either did not include all VHA required information or were not completed within the 30-day timeframe.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires staff to complete discharge documentation in accordance with VHA policy and JC standards.

The VISN and System Directors agreed with the findings and recommendation. Discharge documentation will include all essential elements, and the Chief of Staff will monitor discharge summary completion rates. Results will be discussed at Medical Executive Board meetings and provided to the Medical Records Committee. The

[2] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's senior management team and QM personnel. We evaluated plans, policies, and other relevant QM documents.

The QM program was generally effective in providing oversight of the system's quality of care, and senior managers supported the program. We evaluated 12 QM activities and determined that the system complied with VHA standards in 11 areas. We identified one area that needed improvement.

UM. There was no evidence that a UM physician advisor had fulfilled the responsibilities required by VHA policy.[3] Although two designated physicians had completed the required training in October 2009, no physician was actively involved in the UM program nor had any physicians been trained prior to that time.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that a designated, trained physician serves as an advisor for the UM program, as required by VHA policy.

The VISN and System Directors agreed with the findings and recommendation. Designated physician advisors are now involved in the UM program, and UM staff have developed a spreadsheet to track contacts with the physician advisors. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed 10 files of contracted/agency personnel who worked at the system

[3] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

within the past year and identified two areas that needed improvement.

Background Investigations. U.S. Government agencies are required to complete background investigations for employees in sensitive positions.[4] There was no documentation of completed background investigations for 3 (30 percent) of the 10 contracted/agency RNs.

Clinical Competence. Local policy requires that contracted/agency RNs complete unit-specific competencies before providing patient care. Four (40 percent) of the 10 contracted/agency RNs had not completed unit-specific competencies.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that contracted/agency RNs have evidence of completed background investigations and clinical competence prior to providing patient care.

The VISN and System Directors agreed with the findings and recommendation. The contracting officer has developed a tracking log that includes all required elements for contracted/agency RNs. The automated log will be accessible to nurse managers, and the contracting officer will provide quarterly reports to the Nurse Executive. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physicians' C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[5] We also reviewed meeting minutes that included discussions relevant to the review.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current VHA requirements. Also, meeting

[4] Executive Order 10450, *Security Requirements for Government Employment*, April 27, 1953, Sec. 3.
[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

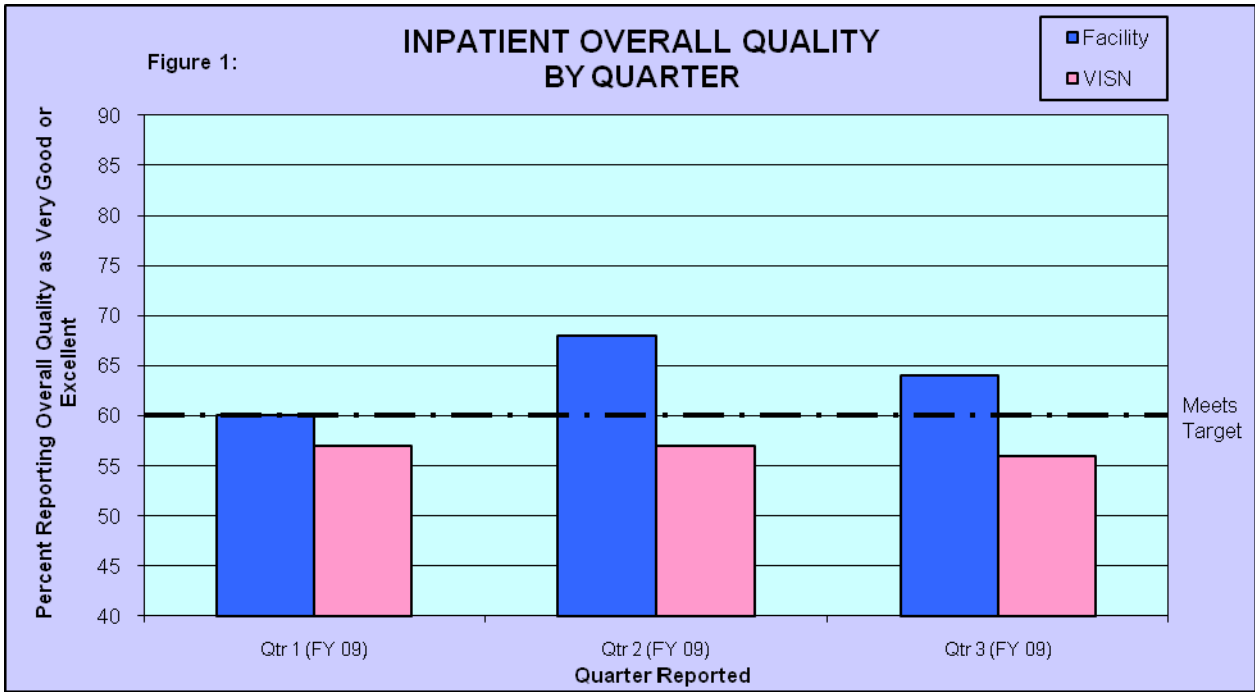
minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending initial or renewal of requested privileges.

Prior to February 2009, the system had not developed the required Focused Professional Practice Evaluations for newly hired physicians. We reviewed the profiles of 40 physicians hired since that time, and the system is now 100 percent compliant with the requirement. Therefore, we made no recommendations.

VHA Satisfaction Surveys

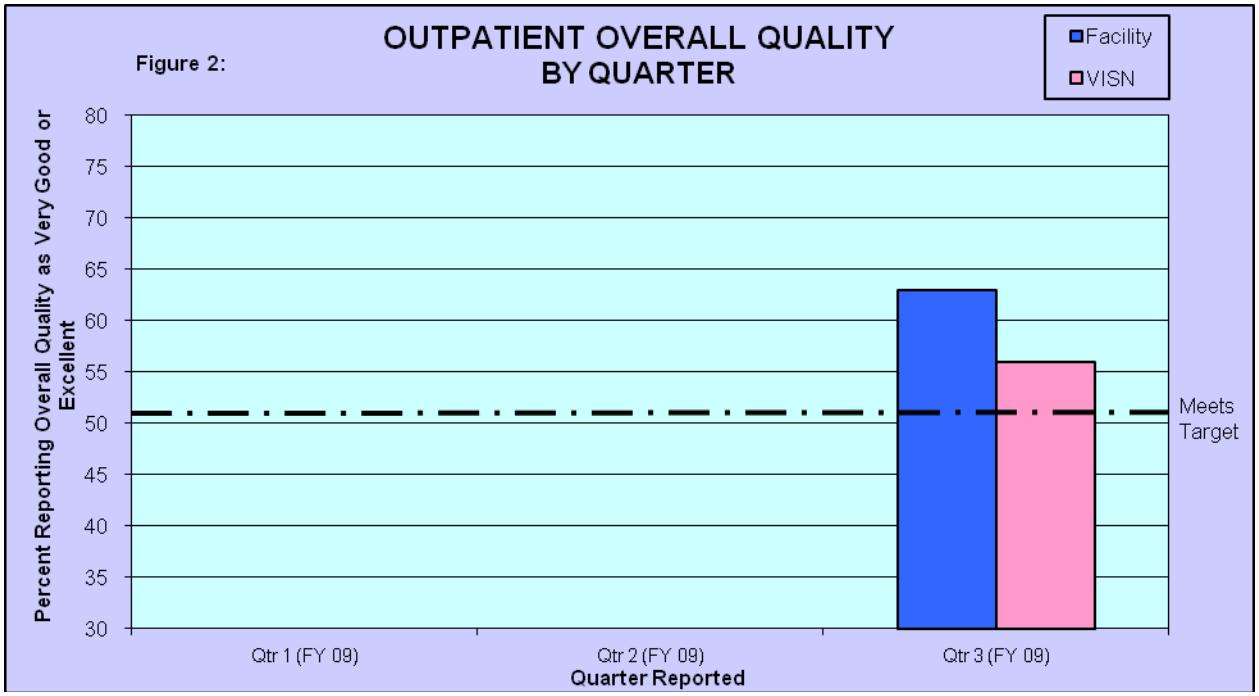
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the system's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[6] The target scores are noted on the graphs.

Figure 1:



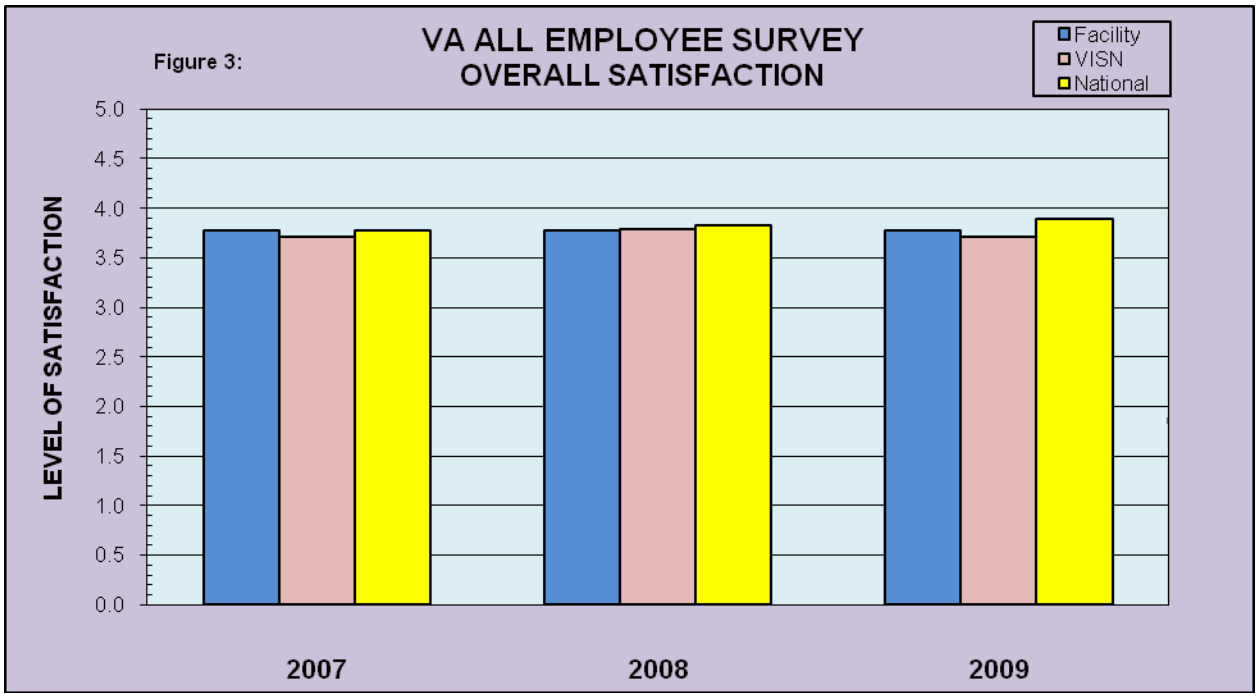
[6] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

Figure 2:



Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 12, 2010

From: Director, VA Heartland Network (10N15)

Subject: **Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Topeka, Kansas**

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

Director, Management Review Service (10B5)

I have reviewed the draft recommendations and responses and concur with them.

(original signed by:)
James R. Floyd

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 4, 2010

From: Director, VA Eastern Kansas Health Care System (589A5/A6/00)

Subject: **Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Topeka, Kansas**

To: Director, VA Heartland Network (10N15)

I have reviewed the issues outlined in the draft report and have implemented actions to address those deficiencies.

(original signed by:)
Judy K. McKee, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that staff cleanse and disinfect equipment between patient uses.

Concur Target Date of Completion: Completed December 23, 2009

Standard Operating Procedure (SOP) #3034 "Cleaning of the Accucheck Inform Glucose Meter" has been written and approved. The SOP mirrors the written cleaning instructions available from the lab as well as the manufacturer's recommendations. The SOP is available to all staff.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that staff identified as at risk for exposure to a harmful atmosphere receive respirator fit testing, training, and medical evaluation, as required.

Concur Target Date of Completion: Completed and ongoing

New employee requirements are captured in New Employee Orientation. Current employees continue to receive PAPR training as they are identified by service lines. For those employees unable to wear a PAPR, or when a PAPR is not practical (e.g., CBOCs), N95 fit testing is available and ongoing. Occupational Health, Safety, and all other service lines are coordinating on identifying employees, medical evaluations, and respirator training and testing.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires all sharps containers to be mounted within the required height range.

Concur Target Date of Completion: January 15, 2010

All containers will be relocated to the appropriate height.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that nurses consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

Concur Target Date of Completion: February 23, 2010

Currently, implementing a new program to improve PRN documentation. New program initiated to provide stop watches/times to nursing staff and monitor documentation of PRN within 2 hr timeframe. Stop watches on order.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that pharmacists consistently perform and document monthly medication reviews on the CLC units.

Concur Target Date of Completion: Completed December 7, 2009

The Pharmacists assigned to the CLC units are now completing all monthly chart reviews. The Pharmacists' supervisors are tracking compliance with this activity.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires staff to complete discharge documentation in accordance with VHA policy and JC standards.

Concur Target Date of Completion: Completed December 23, 2009

Discharge documentation will be in accordance with VHA policy and JC standards. Discharge documentation will include of all essential elements including diet, activity, and follow up (within 7 days for Behavioral Health) in the discharge summary and dictation. Discharge summary completion rates will be monitored by Chief of Staff on a monthly basis, included in discussion at the Medical Executive Board, and given to the HIMS Manager for inclusion in the Medical Records Committee.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that a designated, trained physician serves as an advisor for the UM program, as required by VHA policy.

Concur Target Date of Completion: Completed

Physician advisors were designated in September 2009. Training is complete. UM staff developed a spreadsheet to track physician advisor contact.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that contracted/agency RNs have evidence of completed background investigations and clinical competence prior to providing patient care.

Concur Target Date of Completion: Completed December 18, 2009 and ongoing

The COTR will utilize a tracking log of all active agency staff that includes check off item for verification of completed background check, license, ACLS and BLS expiration dates, mandatory training due dates, initial orientation, initial competency assessment, and annual competency assessment date of completion. COTR has developed usage tracking log and will provide the Nurse Executive a report quarterly. Tracking log will be automated on a shared drive so that all Nurse Managers, NODs, and Associate Chief Nurses can see that an agency employee is up to date on all requirements prior to use of that agency personnel.

OIG Contact and Staff Acknowledgments

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