Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03073-57

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

December 7, 2012

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 crime awareness briefings 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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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Robert J. Dole VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, KS

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 10, 2012.

Review Results: The review covered nine activities. We made no recommendations in the medication management activity.

The facility's reported accomplishment was developing the "Talk To Me" dashboard to improve employees' exchange of information.

Recommendations: We made recommendations in the following eight activities:

Quality Management: Initiate Focused Professional Practice Evaluations for all newly hired licensed independent practitioners, and document all completed ethics consultations.

Moderate Sedation: Include all required elements in the pre-sedation assessment documentation, and appropriately monitor patients during sedation. Discharge moderate sedation outpatients in accordance with Veterans Health Administration requirements. Ensure clinical moderate sedation staff are aware of local policy requirements for identifying surgical and invasive procedure sites when sites cannot be marked.

Coordination of Care: Schedule follow-up appointments within provider requested timeframes. Document care hand-off in accordance with local policy.

Polytrauma: Develop interdisciplinary treatment plans that contain all required elements for polytrauma outpatients. Maintain the minimum staffing level for a rehabilitation nurse. Develop program-specific competencies and training for Polytrauma-Traumatic Brain Injury Program staff.

Environment of Care: Store oxygen tanks in a manner that distinguishes between empty and full tanks. Provide spinal cord injury outpatient clinic employees with population-specific training.

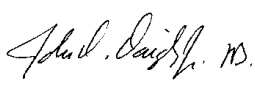
Colorectal Cancer Screening: Notify patients of diagnostic test results within the required timeframe, and document notification.

Nurse Staffing: Implement the mandated staffing methodology for nursing personnel.

Point-of-Care Testing: Inspect all point-of-care testing instruments prior to initial use.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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 administration and QM.
- 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

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities:

- COC
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might 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 2011 and FY 2012 through September 14, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas,* Report No. 11-02716-42, December 8, 2011).

During this review, we presented crime awareness briefings for 71 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 169 responded. We shared survey results with facility managers.

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

Reported Accomplishment

"Talk To Me"

"Talk To Me" is a new employee communication dashboard that was developed through the efforts of a facility Healthcare Failure Mode and Effect Analysis Team. The dashboard was designed to provide employees fast, easy access to information necessary to perform job duties. Selection options are represented by icons that link to corresponding websites. When employees select the appropriate icon, they are immediately provided information and a means to submit questions or reports to managers.

Results

Review Activities With 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 complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
X	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

Noncompliant	Areas Reviewed (continued)
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

FPPE. VHA requires that FPPEs be initiated for all newly hired licensed independent practitioners.[1] We reviewed the profiles of seven newly hired licensed independent practitioners and found that for two of the practitioners, FPPEs had not been initiated.

Integrated Ethics. VHA requires that ethics consultations be documented in ECWeb, a web-hosted database.[2] We reviewed the four ethics consultations that were completed in the last year. Two were not documented in ECWeb.

Recommendations

1. We recommended that processes be strengthened to ensure that FPPEs are initiated for all newly hired licensed independent practitioners.

2. We recommended that processes be strengthened to ensure that all completed ethics consultations are documented in ECWeb.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 6 EHRs, and 55 training/competency records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
X	Monitoring during and after the procedure was appropriate.
X	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
X	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[3] None of the patients' EHRs included all required elements of the history and physical examination, such as a review of substance use or abuse and previous adverse experience with sedation or analgesia.

Intra-Procedure Monitoring. VHA requires that vital signs be documented at 5-minute intervals during the procedure.[4] Four patients' EHRs did not contain documented evidence of vital signs taken at 5-minute intervals.

Appropriate Discharge. VHA requires that moderate sedation outpatients be discharged by a qualified licensed independent practitioner or according to approved criteria.[5] VHA also requires that moderate sedation outpatients be discharged in the company of a responsible, designated adult; discharged to lodging within the facility; or admitted as inpatients. One patient was not discharged by a licensed independent practitioner or according to approved criteria, and another patient was unaccompanied at discharge.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[4] VHA Directive 2006-023.
[5] VHA Directive 2006-023.

Identification of Correct Surgical and Invasive Procedure Site. Local policy requires that a special purpose wristband be placed on a patient when a surgical or invasive procedure site cannot be marked. In three of the four areas where moderate sedation is performed, clinical staff were not aware of this requirement.

Recommendations

3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

4. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

5. We recommended that processes be strengthened to ensure that all moderate sedation outpatients are discharged in accordance with VHA requirements.

6. We recommended that processes be strengthened to ensure that clinical staff in areas where moderate sedation is performed are aware of local policy requirements for identifying correct surgical and invasive procedure sites when the sites cannot be marked.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 24 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
X	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[6] Although provider discharge instructions requested specific follow-up appointment timeframes, 14 appointments were not scheduled as requested.

Hand-Off Communication. Local policy requires that inpatient providers document care hand-off to outpatient providers before patients are discharged. None of the EHRs included documentation of hand-off communication.

Recommendations

7. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

8. We recommended that processes be strengthened to ensure that providers document care hand-off in accordance with local policy.

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

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, 10 EHRs of outpatients in the Polytrauma-TBI Program, and 10 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
X	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed.[7] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. Five of the 10 polytrauma outpatients did not have interdisciplinary treatment plans developed. In addition, three treatment plans did not contain all required elements.

Available Staffing. VHA requires that minimum staffing levels be maintained.[8] The facility did not meet the minimum staffing requirement for a rehabilitation nurse.

[7] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[8] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Polytrauma-TBI Program Specific Competencies and Training. Local policy requires that each service director develop program-specific competencies and training for their employees. Service directors had not developed competencies or training requirements for four employees assigned to the Polytrauma-TBI Program.

Recommendations

9. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need them and that the plans contain all required elements.

10. We recommended that the minimum staffing level for a rehabilitation nurse be maintained.

11. We recommended that processes be strengthened to ensure that service directors develop program-specific competencies and training for all staff assigned to the Polytrauma-TBI Program.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected inpatient units (CLC, medical/surgical, and intensive care), the emergency department, and outpatient clinics (dental, mental health, polytrauma, primary care, and SCI). Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
X	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	Mental Health Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.

Noncompliant	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program (continued)
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Environmental Safety. The Occupational Safety and Health Administration requires that oxygen tanks are stored upright and in a manner which distinguishes between empty and full tanks. We inspected oxygen storage areas on six patient care units. On three units, oxygen tanks were not stored in a manner that distinguished between empty and full tanks.

SCI Training. VHA requires that employees who work with SCI patients receive training specific to that population.[9] The SCI outpatient clinic nurse's training record did not contain documentation of SCI-related training from October 2010 to February 2012.

Recommendations

12. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks.

13. We recommended that processes be strengthened to ensure that SCI outpatient clinic employees receive population-specific training.

[9] VHA Handbook 1176.01, *Spinal Cord Injury and Disorders (SCI/D) System of Care,* February 28, 2011.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[10] Eight of the 11 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Recommendation

14. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

[10] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the mandated staffing methodology for nursing personnel be completed by September 30, 2011.[11] The facility had not implemented the mandated staffing methodology for nursing personnel.

Recommendation

15. We recommended that the facility implement the mandated staffing methodology for nursing personnel.

[11] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of three patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
X	The facility complied with any additional elements required by local policy.

POCT Instrument Management. Local policy requires inspection of all POCT instruments by biomedical engineering prior to initial use. None of the six glucometers we reviewed had been inspected by biomedical engineering.

Recommendation

16. We recommended that processes be strengthened to ensure that all POCT instruments are inspected by biomedical engineering prior to initial use.

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[12] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[12] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Comments

The VISN Director and Acting Facility Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–27 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[13]		
Type of Organization	Acute medical/surgical hospital	
Complexity Level	2b	
VISN	15	
Community Based Outpatient Clinics	Fort Dodge, KS Hays, KS Hutchinson, KS Liberal, KS Parsons, KS Salina, KS	
Veteran Population in Catchment Area	94,158	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	41	
• **CLC/Nursing Home Care Unit**	40	
• **Other**	12 outpatient observation	
Medical School Affiliation(s)	University of Kansas Medical School – Wichita	
• **Number of Residents**	23	
	Current FY (through June 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$179	$179
• **Medical Care Expenditures**	$179	$170
Total Medical Care Full-Time Employee Equivalents	911	925
Workload:		
• **Number of Station Level Unique Patients**	30,115	28,288
• **Inpatient Days of Care:**		
o **Acute Care**	5,971	8,576
o **CLC/Nursing Home Care Unit**	9,381	13,141
Hospital Discharges	1,586	1,957
Total Average Daily Census (including all bed types)	55.9	50.7
Cumulative Occupancy Rate (in percent)	62.55	71.70
Outpatient Visits	224,279	276,425

[13] All data provided by facility management.

VHA Satisfaction Surveys

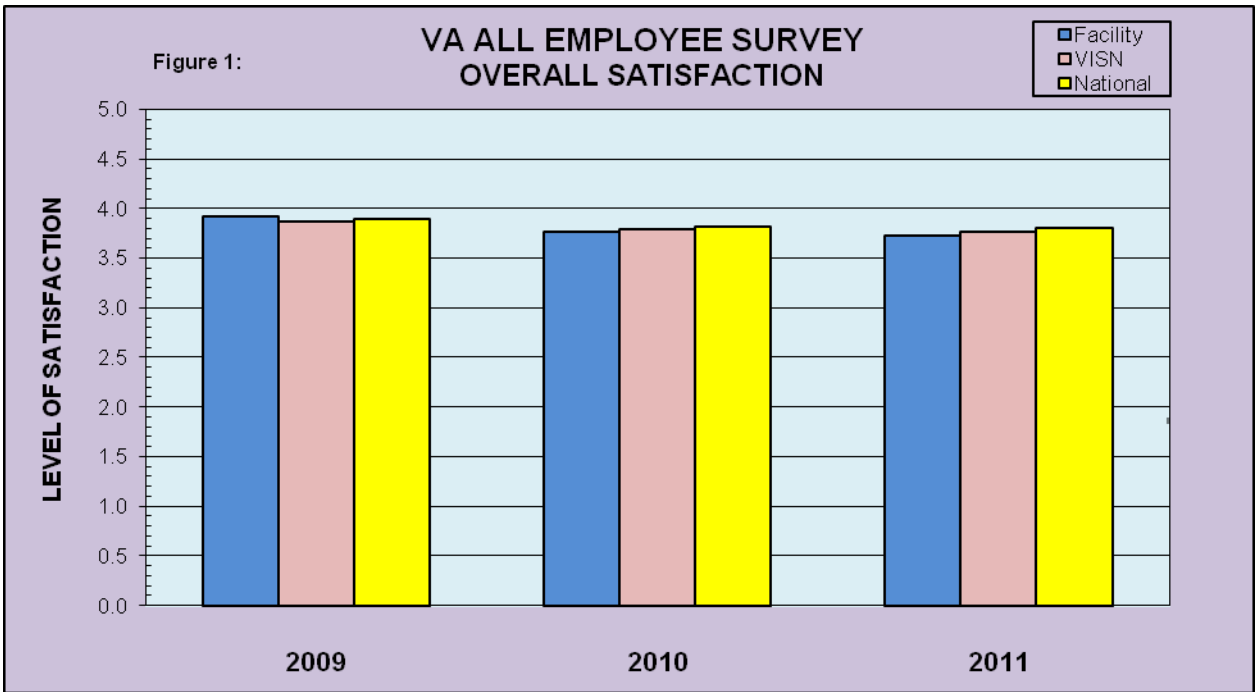
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	62.8	59.6	53.3	52.0	50.0	55.9
VISN	57.8	56.8	52.2	51.7	53.0	55.0
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[14] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[15]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.0	12.4	11.4	18.7	22.3	19.2
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[14] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[15] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 13, 2012

From: Director, VA Heartland Network (10N15)

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

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

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

Attached, please find the initial status response for the Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, KS (Conducted September 10, 2012).

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused towards continuous performance improvement.

For additional questions please feel free to contact Jimmie Bates, VISN 15 Quality Management Officer at 816-701-3014.

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

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 9, 2012

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

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

To: Director, VA Heartland Network (10N15)

I concur with all recommendations. Action plans are attached.

Thank you.

Vicki J Bondie

Vicki Bondie, MBA

Comments to OIG's Report

The following Acting Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that FPPEs are initiated for all newly hired licensed independent practitioners.

Concur

Target date for completion: March 1, 2013

All services have been educated about initiating the required data collection process for FPPEs of newly hired licensed independent practitioners. Processes have been put into effect for the Credentialing & Privileging department to monitor/coordinate the completion of the FPPEs on all new hires. Monitoring tool is under development. These will be monitored by the Chief of Staff on a monthly basis to ensure compliance.

Recommendation 2. We recommended that processes be strengthened to ensure that all completed ethics consultations are documented in ECWeb.

Concur

Target date for completion: March 1, 2013

Select member(s) of the Ethics team will be trained to enter all consults into ECWeb. Training will be completed no later than November 30, 2012. Monitoring will occur to compare the consults with the ECWeb entries and reported to the Service Line Director and then the Acting Facility Director.

Recommendation 3. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: March 1, 2013

Processes to ensure pre-sedation assessment documentation for the endoscopy and operating room areas have been completed. Process strengthening has included template modification and use. Monitoring is set to begin immediately by Service Line and reported to the Chief of Staff.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

Concur

Target date for completion: March 1, 2013

Review of intra-procedure monitoring and documentation found appropriate processes in place with issue identified with the scanning process of paper records. On the spot staff training was completed with immediate resolution of procedural scanning error. Charts reviewed currently indicate entire vital signs page being scanned into CPRS. Monitoring of scanned intra-procedure documentation will continue and be reported to the appropriate council/Chief of Staff and Executive Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that all moderate sedation outpatients are discharged in accordance with VHA requirements.

Concur

Target date for completion: March 1, 2013

Evaluation of current policies and processes is planned as well as monitoring after re-education of the staff with follow up through the Nurse Executive. The process for discharge of all outpatients has been reviewed with staff in the Cardiac Catheterization Laboratory. All staff can verbalize the requirements. Additionally, the note in CPRS has been updated to require a co-signature. Completion of process evaluation and full resolution of issue with monitoring will be reported to the appropriate council and Leadership.

Recommendation 6. We recommended that processes be strengthened to ensure that clinical staff in areas where moderate sedation is performed are aware of local policy requirements for identifying correct surgical and invasive procedure sites when the sites cannot be marked.

Concur

Target date for completion: January 31, 2013

This was specific to areas of interventional radiology/cardiology. The supervisors of the areas immediately re-educated their staff to the local policy (CPC 11-03 Ensuring Correct Surgery and Invasive Procedures) which involved using “a special-purpose wristband.” Supervisors of the appropriate areas have certified that the proper wristbands for procedure/site identification are available in the area. Staff are randomly checked for compliance. Tracers in the areas completed since the OIG review shows compliance with staff knowledge and wristband usage. Monitors will be completed and reported to the appropriate council and Leadership.

Recommendation 7. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: March 1, 2013

There has been inconsistent staff coverage for scheduling follow-up appointments for patients who are discharged from the inpatient service. The facility approved the hiring of a clerk who will be dedicated to scheduling follow-up appointments for patients who are discharged from the inpatient unit. In addition, the Outpatient Patient Aligned Care Team are making follow-up calls to patients discharged from the inpatient service within 2 days of the discharge.

Recommendation 8. We recommended that processes be strengthened to ensure that providers document care hand-off in accordance with local policy.

Concur

Target date for completion: March 1, 2013

The process of the existing verbal hand-off communication by inpatient providers to outpatient providers is being strengthened to include documentation as per local policy. Education of staff involved is in progress regarding the completion of the template in CPRS. Monitoring will be initiated with monthly report to the Service Line Director and Executive Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need them and that the plans contain all required elements.

Concur

Target date for completion: March 1, 2013

Interdisciplinary treatment plans that cover all required elements have been initiated by the Polytrauma Support Clinic Team as of October 30, 2012. The Polytrauma Support Clinic Team Program Manager is maintaining a patient roster to ensure treatment plans are reviewed and updated. Monitoring data will be reported to the appropriate council and Executive Committee.

Recommendation 10. We recommended that the minimum staffing level for a rehabilitation nurse be maintained.

Concur

Target date for completion: November 1, 2013

Staffing is currently being addressed by the Chief, Physical Medicine and Rehabilitation Service and Primary Care. There are two full time Registered Nurses who share duties with the Polytrauma-TBI program. Both nurses are working towards getting Rehabilitation Nursing certification. This is a lengthy process but anticipate completion of the process over the next year.

Recommendation 11. We recommended that processes be strengthened to ensure that service directors develop program-specific competencies and training for all staff assigned to the Polytrauma-TBI Program.

Concur

Target date for completion: December 31, 2012

The Chief, Physical Medicine and Rehabilitation Service is currently developing/updating the competencies and training for all staff assigned to the Polytrauma-TBI program. Nursing competencies are completed. A Standard Operating Procedure for the Polytrauma Clinic will be completed by December 31, 2012. Additional disciplines' competencies will be implemented as they are developed. Monitoring information will be reported to the appropriate council and Leadership.

Recommendation 12. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks.

Concur

Target date for completion: December 31, 2012

The facility approved procedure for oxygen tank storage was reviewed with the Nurse Managers and the Director of Logistics; each has reviewed with their staff. Random checks are being completed by the Patient Safety Manager on weekly Environment of Care rounds along with unit tracers performed by managers and QM team.

Recommendation 13. We recommended that processes be strengthened to ensure that SCI outpatient clinic employees receive population-specific training.

Concur

Target date for completion: December 31, 2012

Primary Care Associate Director is developing population-specific training to be provided for all employees who work with SCI patients.

Recommendation 14. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: November 5, 2012

The Endoscopy department had been notifying patients of their endoscopy results by handing patients a hand written report of their colonoscopy results on the day of their procedure. Effective October 1, 2012, Wichita VA started scanning these reports into CPRS to maintain a record of notifying patients of their colonoscopy results in CPRS.

All colonoscopies completed in October 2012 were reviewed to determine compliance with scanning of the handwritten results given to the patients. Compliance was 94 percent.

Recommendation 15. We recommended that the facility implement the mandated staffing methodology for nursing personnel.

Concur

Target date for completion: February 1, 2013

The staffing methodology process has been implemented in compliance with VHA Directive 2010-034 STAFFING METHODOLOGY FOR VHA NURSING PERSONNEL. All nursing staff are required to complete the web-based training. As of November 6, 2012, 84 percent have completed the training. The Deputy Nurse Executive receives a weekly progress report and forwards this to the Associate Director Patient Care/Nurse Executive as well as the Nurse Managers.

Intensive Care Unit, Med/Surg, and CLC conducted their Unit Based Expert Panel meetings, developed and submitted their recommendations on October 15, 2012. The Facility Based Expert Panel convened, reviewed, revised, and approved recommendations on October 17, 2012. Recommendations were forwarded to the Associate Director Patient Care/Nurse Executive on October 22, 2012. Recommendations were approved and signed by the Medical Center Director on November 6, 2012.

Meetings with the Associate Director Patient Care/Nurse Executive, Deputy Nurse Executive, and the Nurse Managers of CLC, Med-Surg, and Intensive Care Unit continue. Review of a daily staffing tool will be utilized to allow for daily tracking of census, staffing and Nursing Hours per Patient Day.

Recommendation 16. We recommended that processes be strengthened to ensure that all POCT instruments are inspected by biomedical engineering prior to initial use.

Concur

Target date for completion: Completed November 2, 2012

Processes are developed to ensure that all POCT instruments will be inspected by biomedical engineering prior to initial use. The local policy is current. The laboratory contractual blood glucose meters were inspected and properly identified by Bio Med and Laboratory as of November 2, 2012. As units are removed from service or received into the system, the POCT Coordinator will notify Logistics who will make the adjustment in equipment records. Records of arrival of new meters and all other meters are recorded in the Remote Automated Laboratory System. A new item load into the data management system will trigger an initial inspection by biomedical engineering prior to initial use. Information has been communicated to the Clinical Support Program Director who reports to the Chief of Staff.

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