Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01294-224

Combined Assessment Program Review of the VA Black Hills Health Care System Fort Meade, South Dakota

July 25, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

AIS	acute ischemic stroke
CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Black Hills Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of May 19, 2014.

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

- Coordination of Care
- Community Living Center Resident Independence and Dignity

The facility's reported accomplishment was improved efficiency and utilization in orthopedics.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that the Clinical Executive Council documents its discussion of Peer Review Committee quarterly summary reports. Implement a local observation policy that includes all required elements. Reassess observation criteria and utilization timely when conversions from observation bed status to acute admissions are over 30 percent. Perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure the Surgical Staff Committee meets monthly, includes the Chief of Staff as a member, and documents its review of National Surgery Office reports. Require that the quality of entries in the electronic health record is reviewed and data analyzed at least quarterly and that the review includes most services. Ensure the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Environment of Care: Ensure infection prevention materials are available for eye clinic patients, visitors, and family members. Reprocess ophthalmology lenses and pachymetry probes in accordance with manufacturers' instructions.

Medication Management: Document patient learning assessments within 8 hours of admission.

Acute Ischemic Stroke Care: Develop an acute ischemic stroke policy that addresses all required items, and fully implement the policy. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on all acute inpatient units. Collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Magnetic Resonance Imaging Safety: Conduct contrast reaction drills in the magnetic resonance imaging mobile unit at the Hot Springs division. Ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objective and Scope

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- AIS Care
- CLC Resident Independence and Dignity
- MRI Safety

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

The review covered facility operations for FY 2012, FY 2013, and FY 2014 through May 23, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Black Hills Health Care System, Fort Meade, South Dakota,* Report No. 11-03661-76, January 31, 2012). We made a repeat recommendation in QM.

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 319 responded. We shared summarized results with the facility Director.

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

Improved Efficiency and Utilization in Orthopedics

The facility's orthopedics team took part in a specialty collaborative where they worked to optimize time utilization and improve operation measures. To achieve these outcomes, they mapped out provider time and found ways to add additional time slots during the day by reducing computer log on and log off time through laptop implementation. They optimized operating room time by adding extra surgeries daily. In addition, the group reduced missed opportunity rates through the adoption of nontraditional care modalities, including the use of clinical video telehealth for remote community based outpatient clinics, secure messaging, and the use of phone encounters.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twelve months of Clinical Executive Council meeting minutes reviewed: • Unusual findings from all 4 quarters' summary reports were not documented as discussed.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings (continued)
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	• The facility did not have a local policy. Seven months of data reviewed: • For 4 months, 30 percent or more of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization during that time.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Nine months of continuing stay data reviewed: • For all 9 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Staff Committee only met 6 times over the past 12 months. Six sets of Surgical Staff Committee meeting minutes reviewed: • The Chief of Staff was not a member. • There was no evidence that National Surgery Office reports were reviewed.
	• Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	• There was no evidence that the quality of entries in the EHR was reviewed. This was a repeat finding from the previous CAP review. Twelve months of Medical Records Review Committee meeting minutes reviewed: • EHR quality data was not analyzed quarterly. • The review of EHR quality did not consistently include EHRs from Medicine, Surgery, Nursing, Dental, Primary Care, and Rehabilitation Services.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings (continued)
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Three sets of Blood Utilization Committee meeting minutes reviewed: • The clinical representative from Surgery Service missed two of the three meetings.
	• Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Clinical Executive Council document its discussion of Peer Review Committee quarterly summary reports, including unusual findings or patterns.

2. We recommended that a local observation bed policy that includes all required elements be implemented.

3. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

4. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

5. We recommended that the Surgical Staff Committee meet monthly, include the Chief of Staff as a member, and document its review of National Surgery Office reports.

6. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed and data analyzed at least quarterly and that the review of electronic health record quality includes most services.

7. We recommended that processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends meetings.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

At the Fort Meade division, we inspected the locked inpatient mental health unit; the medical and surgical inpatient unit; the intensive care unit; the PACU; the CLC; the emergency department; and the primary care, podiatry, and eye clinics. At the Hot Springs division, we inspected the urgent care, podiatry, and eye clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 16 employee training records (13 PACU and 3 eye clinic). The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
NA for SDS	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
NA	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
NA for SDS	Fire safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
NA for SDS	Environmental safety requirements in SDS and on the PACU were met.	
NA	SDS medical laser safety requirements were met.	
NA for SDS	Infection prevention requirements in SDS and on the PACU were met.	
NA for SDS	Medication safety and security requirements in SDS and on the PACU were met.	
NA for SDS	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
	Designated eye clinic employees received laser safety training with the frequency required by local policy.	
	Environmental safety requirements in the eye clinic were met.	
X	Infection prevention requirements in the eye clinic were met.	• The eye clinic had no infection prevention educational materials for patients, visitors, or family members. • Employees did not reprocess ophthalmology lenses and pachymetry probes according to manufacturers' instructions.
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

8. We recommended that processes be strengthened to ensure that infection prevention educational materials are available for eye clinic patients, visitors, and family members.

9. We recommended that processes be strengthened to ensure that employees reprocess ophthalmology lenses and pachymetry probes in accordance with manufacturers' instructions and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	• For 17 patients (50 percent), learning assessments were conducted more than 8 hours after admission.
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

10. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 8 hours of admission and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of three patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

AIS Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an AIS.[e]

We reviewed relevant documents and the EHRs of 13 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the emergency department, one urgent care clinic, one critical care unit, and two acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility's stroke policy/plan/guideline addressed all required items.	• The facility did not have an AIS policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• None of the nine applicable EHRs contained documented evidence of completed stroke scales.
	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on the two acute inpatient units.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
	Clinicians provided printed stroke education to patients upon discharge.	
	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were consistently collected and reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

13. We recommended that stroke guidelines be posted on all acute inpatient units.

14. We recommended that the facility collect and report to the VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 12 EHRs of residents (10 residents receiving restorative nursing services and 2 residents not receiving restorative nursing services but candidates for services). We also observed 43 residents during 2 meal periods, reviewed 6 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

We reviewed relevant documents and the training records of 25 employees (21 randomly selected Level 1 ancillary staff and 4 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed 29 EHRs of randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area at the Fort Meade division. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	• Contrast reaction drills were not conducted in the MRI mobile unit at the Hot Springs division.
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member or caregiver and reviewed and signed by a Level 2 MRI personnel.	
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Five Level 1 ancillary staff did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

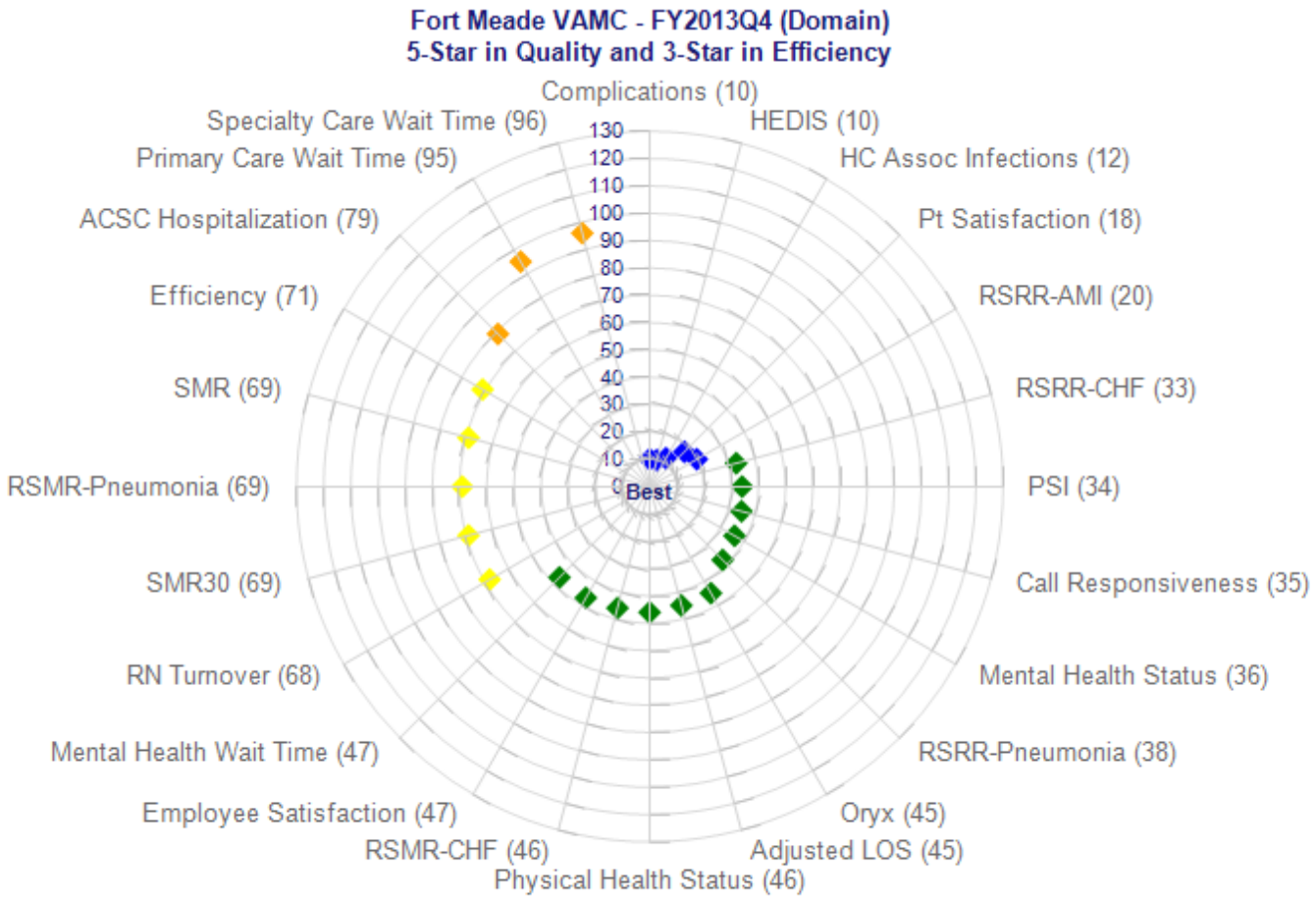
15. We recommended that processes be strengthened to ensure that contrast reaction drills are conducted in the magnetic resonance imaging mobile unit at the Hot Springs division and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Facility Profile (Fort Meade/568) FY 2014 through May 2014[1]	
Type of Organization	Tertiary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$170.9
Number of:	
• **Unique Patients**	17,771
• **Outpatient Visits**	162,927
• **Unique Employees**[2]	805
Type and Number of Operating Beds (April 2014):	
• **Hospital**	44
• **CLC**	104
• **Mental Health**	112
Average Daily Census (April 2014):	
• **Hospital**	20
• **CLC**	58
• **Mental Health**	87
Number of Community Based Outpatient Clinics	10
Location(s)/Station Number(s)	Rapid City/568GA Pierre/568GB Newcastle/568HA Gordon/568HB Alliance/568HC Pine Ridge/568HF Gering/568HH Rosebud/568HJ Eagle Butte/568HM Winner/568HP
VISN Number	23

[1] All data is for FY 2014 through May 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

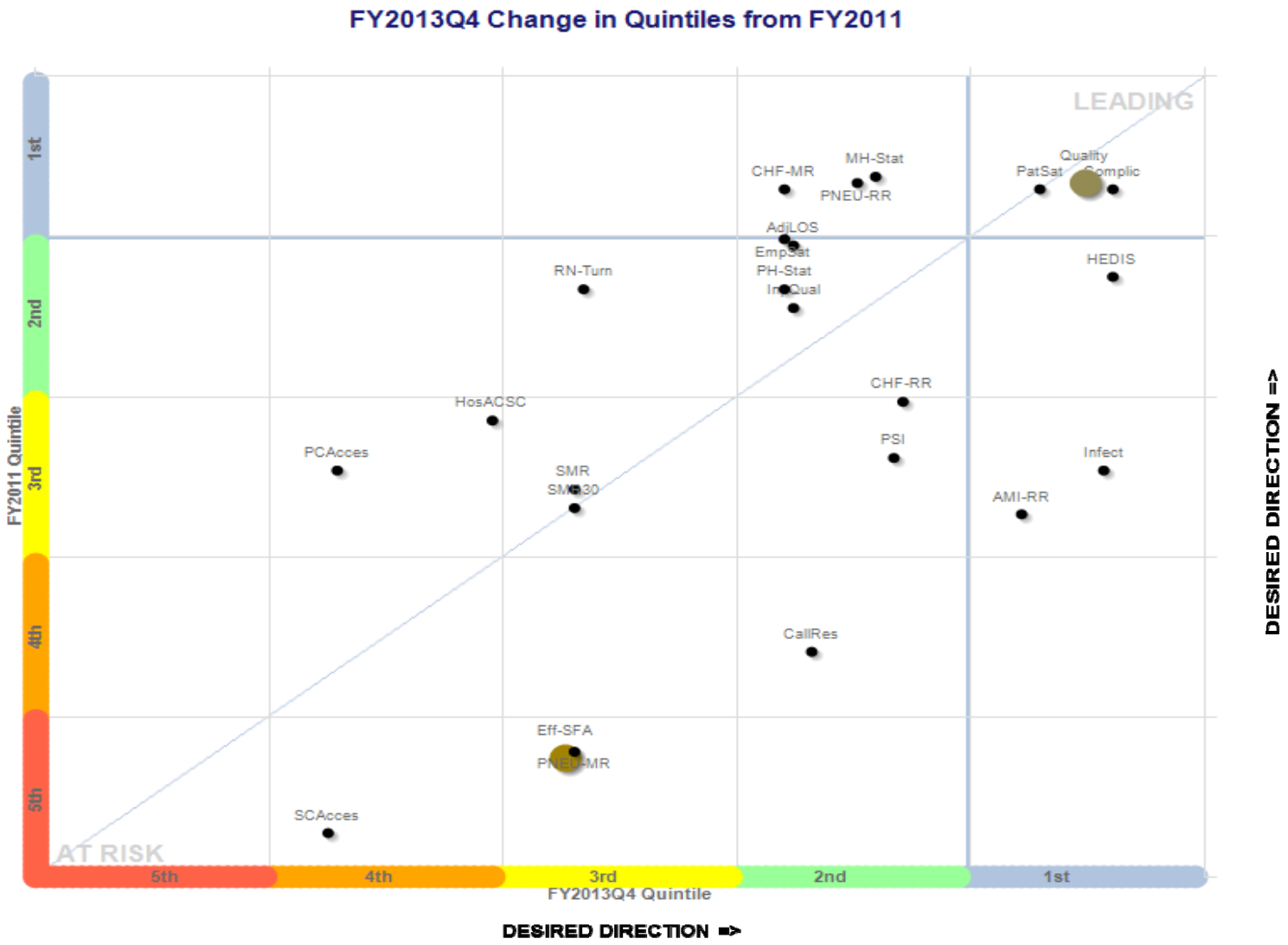
Strategic Analytics for Improvement and Learning (SAIL)[3]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 23, 2014

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the VA Black Hills Health Care System, Fort Meade, SD**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

I concur with VA Black Hills Health Care System, Ft. Meade, SD response to the Draft OIG CAP completed May 19–May 23, 2014.

If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

(*original signed by:)*
Steven C. Julius, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 23, 2014

From: Director, VA Black Hills Health Care System (568/00)

Subject: **CAP Review of the VA Black Hills Health Care System, Fort Meade, SD**

To: Director, VA Midwest Health Care Network (10N23)

Attached please find our VHA Facility response to the Draft OIG CAP completed May 19–May 23, 2014.

If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511, Extension 7170.

(*original signed by:)*
Stephen R. DiStasio, FACHE
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 Clinical Executive Council document its discussion of Peer Review Committee quarterly summary reports, including unusual findings or patterns.

Concur

Target date for completion: October 31, 2014

Facility response: Peer Review Committee summary reports are presented, reviewed and any trends identified by the Clinical Executive Council (CEC) every quarter. The CEC minutes will reflect the analysis of the presented information.

Compliance will be validated by submission of excerpt of minutes that reflect analysis of data and actions related to the data if indicated for two reporting periods of FY 14 Quarter 2 and Quarter 3.

Recommendation 2. We recommended that a local observation bed policy that includes all required elements be implemented.

Concur

Target date for completion: October 1, 2014

Facility response: Policy COS-49 Facility Observation Policy was drafted and approved by the Clinical Executive Council on May 6, 2014, approved at the Executive Leadership Board on May 29, 2014 and signed by the Medical Center Director and published on the facility policy Share Point on June 20, 2014. Education was implemented and continued on the draft policy through the duration of the process of approval and was completed by May 5, 2014 by 100% of the affected employees.

Validation will be submission of signed policy verifying publication.

Recommendation 3. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

Concur

Target date for completion: October 1, 2014

Facility response: Data on conversion from observation bed status to acute admissions is included at the weekly Wednesday Leadership meeting as new data becomes available. This process was initiated on April 23, 2014 and current data demonstrates that FY YTD data for conversions is at 25.6%, with May 2014 conversions being at 17.6%. New 48 hour observation status per Directive initiated on April 28, 2014.

Evidence of compliance will be the VA Black Hills Health Care System Observation conversion data through August 2014 and excerpts from Clinical Executive Council minutes reflecting presentation, discussion and analysis of data with action plans required for conversion data above 30%.

Recommendation 4. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: October 1, 2014

Facility response: Continued stay review completion data for review is included at the weekly Wednesday Leadership meeting. This process was initiated on June 4, 2014 and current data demonstrates 100% of continued stay reviews completed for April and May 2014.

Evidence of compliance will be the VA Black Hills Health Care System Continued Stay review completion rates through August 2014 demonstrating 3 consecutive months of 75% or greater review.

Recommendation 5. We recommended that the Surgical Staff Committee meet monthly, include the Chief of Staff as a member, and document its review of National Surgery Office reports.

Concur

Target date for completion: December 31, 2014

Facility response: The Surgical Staff committee is scheduled to meet monthly. The Chief of Staff was included on membership as of June 1, 2014. Alternatives to scheduling dates are in the process of review to ensure Chief of Staff availability for attendance.

National Surgery Office (NSO) reports are scheduled for reporting and analysis on the month following release of the quarter and annual reports.

Validation of compliance will be submission of Surgery Committee attendance logs and excerpts from Surgery Committee minutes reflecting discussion and analysis of NSO data.

Recommendation 6. We recommended that processes be strengthened to ensure that the quality of entries in the electronic health record is reviewed and data analyzed at least quarterly and that the review of electronic health record quality includes most services.

Concur

Target date for completion: December 31, 2014

Facility response: Medical Records committee meets monthly and reviews and analyzes Electronic Health Record (EHR) quality of documentation data quarterly for Medical, Surgical, Mental Health, Dental, Extended Care and Rehabilitation and Nursing. Quality data not meeting the identified performance standard of 90% will require action plans for submission to committee for review and analysis. Medical Records Committee Charter to be revised to reflect changes in reporting schedule requirement.

Validation of compliance will be submission of revised reporting schedule, revised charter, and excerpts of Medical Records Committee reflecting 2 quarters of reporting, discussion and analysis of data for each of the identified services.

Recommendation 7. We recommended that processes be strengthened to ensure that the Blood Utilization Committee member from Surgery Service consistently attends meetings.

Concur

Target date for completion: October 1, 2014

Facility response: The VA Black Hills Health Care System has revised the Blood Utilization Committee membership to be in compliance with the VHA Directive. Revised membership has been present at the past two quarterly meetings dated March 18, 2014 and May 20, 2014 respectively. Membership attendance will be reported to the Clinical Executive Council with submission of the minutes.

Validation of compliance will be submission of attendance roster from 3 quarterly meetings.

Recommendation 8. We recommended that processes be strengthened to ensure that infection prevention educational materials are available for eye clinic patients, visitors, and family members.

Concur

Target date for completion: October 1, 2014

Facility response: Infection Prevention pamphlets distributed to the Ft. Meade Eye clinic on May 22, 2014 and at the Hot Springs eye clinic on May 23, 2014. Education to

100% Specialty Clinic employees on the presence of the education material and restocking process of education material to be completed by July 1, 2014

Compliance will be monitored by monthly rounds by the Infection Prevention Coordinator and continue until 90% of units rounded have infection prevention educational material for 3 consecutive months. Data that will be collected will be:

Numerator = # of clinical areas with infection prevention education material

Denominator = # of clinical areas audited

Recommendation 9. We recommended that processes be strengthened to ensure that employees reprocess ophthalmology lenses and pachymetry probes in accordance with manufacturers' instructions and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: The VA Black Hills Health Care System has revised the Standard Operating Procedures for the Volk lens and the DGH Pachymeter according to manufacturer's instructions and approval by the Reusable Medical Equipment Committee received by June 20, 2014. Education of 100% of required staff will be completed by July 15, 2014.

Validation of compliance with reprocessing will occur by direct observation of reprocessing of the DGH Pachymeter by unit manager or SPS Chief for 30 days or until competency achieved. Results will be presented for discussion and analysis by the Reuseable Medical Equipment Committee (RME) on a monthly basis unit 3 consecutive months of 90% or greater compliance is achieved.

Recommendation 10. We recommended that processes be strengthened to ensure that patient learning assessments are documented within 8 hours of admission and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Patient learning assessments are documented within 8 hours of admission. Learning assessments which will include specific deficits such as vision, hearing, ability to read, and cognitive status will be added to the Nursing admission template by October 1, 2014. Changes to the nursing admission template is a collaborative effort by Nursing leaders and clinical application staff.

Education on additional documentation requirements will be completed by October 1, 2014. The process for monitoring compliance will be implemented on

October 1, 2014 and be measured monthly until targeted performance of 90% for 3 consecutive months is achieved.

Data audited:

Numerator = # of records in compliance with learning needs assessment completed on admission and discharge

Denominator = the # of patient records reviewed

Recommendation 11. We recommended that the facility develop an acute ischemic stroke policy that addresses all required items, that the policy be fully implemented, and that compliance be monitored.

Concur

Target date for completion: November 1, 2014

Facility response: The VA Black Hills Health Care System will develop a policy defining the treatment of Acute Ischemic Stroke (AIS) for a Limited Hours facility level of care as required by VHA Directive by August 1, 2014. Education of VA Black Hills Health Care System identified staff will be completed by August 31, 2014.

The infrastructure at the VA BHHCS will be reviewed with VHA and VISN to ensure compliance with a Limited Hours facility designation.

Validation of compliance with VHA Directive and the facility policy will be monitored through the Critical Care Committee (CCC) and reported to leadership through the Clinical Executive Council (CEC) on a quarterly basis. Excerpts from CCC and CEC minutes reflecting compliance from the October 2014 meeting will be submitted.

Recommendation 12. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: November 1, 2014

Facility response: The VA Black Hills Health Care System will initiate completion of the National Institutes of Health (NIH) stroke scales by August 1, 2014 post completion of education of 100% of Emergency Department, Urgent Care and ICU staff on the NIH stroke scale.

Validation of compliance will be review of the data on completion of the required elements, discussion and analysis monthly at the Critical Care Committee (CCC) with compliance reported quarterly to the Clinical Executive Council demonstrating a minimum 3 consecutive months of 90% performance.

Recommendation 13. We recommended that stroke guidelines be posted on all acute inpatient units.

Concur

Target date for completion: July 31, 2014

Facility response: The VA Black Hills Health Care System will post the facility stroke flowchart for recognition and treatment of AIS according to local policy in all outpatient and inpatient areas by July 31, 2014.

Recommendation 14. We recommended that the facility collect and report to the VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: November 1, 2014

Facility response: The VA Black Hills Health Care System will collect, review, and analyze data at the Critical Care Committee monthly and report quarterly through the Clinical Executive Council. Data will be entered into the IPEC data base as required.

Validation of compliance will include 3 months of collection data, excerpts from Critical Care Committee minutes and Clinical Executive Council minutes reflecting discussion and analysis of the required data.

Recommendation 15. We recommended that processes be strengthened to ensure that contrast reaction drills are conducted in the magnetic resonance imaging mobile unit at the Hot Springs division and that compliance be monitored.

Concur

Target date for completion: October 1, 2014

Facility response: The VA Black Hills Health Care System strengthened the process for completion of the required MRI safety drills including Contrast Reaction at both the Ft. Meade and Hot Springs site by developing a Standard Operating Procedure (SOP) identifying the schedule for completion.

The VA Black Hills has completed mock contrast drills at both locations as of June 20, 2014. Compliance with the completion of the required safety drills will be reported at the VISN MRI Committee with quarterly reporting to the Clinical Executive Council by the Medical Director for Radiology.

Validation of compliance will be submission of the SOP, and evidence of completed drills through September 30, 2014.

Recommendation 16. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: December 31, 2014

Facility response: Current Employees: All designated Level 1 ancillary staff have Talent Management System (TMS) training module #1345270 MRI Safety-Level 1 assigned to their annual learning plan. Current compliance rate 95%. Newly Hired Employees: The process for completion of Level 1 magnetic resonance imaging safety training will be revised by August 1, 2014 to decrease the time frame for completion to 60 days within hire at the VA Black Hills Health Care System for all clinical staff. This process includes the Talent Management System (TMS) training module #1345270 MRI Safety-Level 1.

Validation of compliance will consist of monthly data collection of new employees hired from August 1, 2014 and later and compliance with completion of the required TMS module post 60 days from hire.

Numerator = # of new clinical employees hired within the monitored month with MRI Safety Level 1 training completed within 60 days of hire

Denominator = All clinical employees hired within the monitored month

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Endnotes

[a] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
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- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
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- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- "Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks –Four States, 2008–2010," Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, August 16, 2013.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[d] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.

[g] References used for this topic included:

- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
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- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.