Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02064-252

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

October 2, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
DOM	domiciliary
ED	emergency department
EHR	electronic health record
EOC	environment of care
facility	VA Eastern Kansas Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
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
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 June 9, 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 accomplishments were adding an onsite pharmaceutical dispensing script center and the Healthcare Field Analytics Program.

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee and that the Peer Review Committee consistently submits quarterly summary reports to the Medical Executive Committee. Require the Surgical Work Group to meet monthly and to consistently document its review of National Surgical Office reports. Analyze data from electronic health record quality reviews at least quarterly. Include in the quality control policy for scanning how a scanned image is annotated to identify that it has been scanned. Ensure the Tissue and Transfusion Committee member from Anesthesia Service consistently attends meetings.

Environment of Care: Ensure damaged optical examination chairs in the eye clinics are repaired or removed from service.

Medication Management: Ensure clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient, and provide printed stroke education to patients upon discharge. Ensure staff involved in assessing and treating stroke patients receive the training required by the facility. Collect and report to the Veterans Health Administration 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 emergency drills in magnetic resonance imaging (MRI). Conduct initial patient safety screenings. Ensure radiologists and/or Level 2 MRI personnel document resolution in patients' electronic health records of all identified MRI contraindications prior to the scan. Require that all

designated Level 1 ancillary staff receive annual level-specific MRI safety training. Ensure appropriate signage and barriers are in place at the Leavenworth division to restrict access to Zone III. Require that the MRI Safety Committee and the Patient Safety Manager evaluate the identified potential safety and security risks and take appropriate actions.

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 consider recommendation 17 closed. We will follow up on the planned actions for the open recommendations 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
- Acute Ischemic Stroke 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 2013 and FY 2014 through June 10, 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 Eastern Kansas Health Care System, Topeka, Kansas,* Report No. 11-04568-148, April 10, 2012).

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 463 responded. We shared summarized 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 Accomplishments

Onsite Pharmaceutical Dispensing Script Center

The DOM MH Residential Rehabilitation Treatment Program added an onsite pharmaceutical dispensing script center. This accomplishment was the result of a Systems Redesign project to reduce the number of DOM patients refilling prescriptions at the outpatient pharmacy window. This was a patient safety concern because many of the patients were unable to make the trip from the DOM to the pharmacy window in the main building. The Systems Redesign project team determined that a kiosk was appropriate for the DOM's needs and worked with contracting personnel in order to procure the equipment to make this idea a reality.

Healthcare Field Analytics Program

The Healthcare Analytics Certificate Program is a collaborative effort between Nebraska Methodist College and the VA Nebraska-Western Iowa Health Care System. The four non-credit courses in the program enable participating staff to develop the knowledge and skills to be able to lead data analysis and improvement efforts. Since each course builds upon the prior one, students take the courses in order. All courses are taught online using a mix of asynchronous and synchronous approaches. Seven current employees have graduated from the program, and nine employees are now active in the program. The facility was a pilot facility for field analytics in 2011 and now has the Western Orbit Knowledge Management and Analytics Service.

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.	Six months of PRC meeting minutes reviewed: • Of the 27 actions expected to be completed, 25 were not were reported to the PRC. Twelve months of MEC meeting minutes reviewed: • Only two quarterly summary reports were documented as received by the MEC.
	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
	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.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	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 Work Group only met 7 times over the past 9 months. Seven months of Surgical Work Group meeting minutes reviewed: • There was no evidence that National Surgical Office reports were reviewed for 2 of the 3 quarters.
	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.	Medical Records Committee meeting minutes reviewed: • EHR quality data was analyzed for only 2 quarters.
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include how a scanned image is annotated to identify that it has been scanned.

NM	Areas Reviewed (continued)	Findings
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.	Four quarters of Tissue and Transfusion Committee meeting minutes reviewed: • The clinical representative from Anesthesia Service attended only two of four 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 processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

2. We recommended that the Peer Review Committee consistently submit quarterly summary reports to the Medical Executive Committee.

3. We recommended that the Surgical Work Group meet monthly and consistently document its review of National Surgical Office reports.

4. We recommended that processes be strengthened to ensure that data from electronic health record quality reviews are analyzed at least quarterly.

5. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

6. We recommended that processes be strengthened to ensure that the Tissue and Transfusion Committee member from Anesthesia 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 PACUs, and the eye clinics.[b]

At the Topeka division, we inspected inpatient units (CLC, intensive care, medical/surgical, and MH), outpatient clinics (dental, eye, primary care, rehabilitation, and SDS), specialty care clinics (endoscopy, orthopedics, otolaryngology, podiatry, surgery), the PACU, and the urgent care clinic. At the Leavenworth division, we inspected inpatient units (CLC, intensive care, and medical/surgical), outpatients clinics (cardiology, dermatology, eye, and primary care), the DOM, the ED, the PACU, and SDS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 44 employee training records (29 SDS, 10 PACU, and 5 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	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and PACU (continued)	Findings
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	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.	
X	Environmental safety requirements in the eye clinic were met.	• Six of nine optical examination chairs had cracked or torn arm rests.
	Infection prevention requirements in the eye clinic were met.	
	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.	

Recommendation

7. We recommended that processes be strengthened to ensure that damaged optical examination chairs in the eye clinics are repaired or removed from service.

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 32 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
X	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	• For the 3 of the 10 patients with identified learning barriers, EHR documentation did not reflect medication counseling accommodation to address the barriers.
	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

8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers 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 seven 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.	

Acute Ischemic Stroke 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 acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 25 patients who experienced stroke symptoms, and 10 employee training records (2 ED, 2 urgent care clinic, 3 intensive care unit, and 3 nursing), and we conversed with key employees. We also conducted onsite inspections of acute inpatient units, critical care units, the ED, and the urgent care clinic. 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
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Eleven of 17 applicable EHRs did not contain documented evidence of completed stroke scales.
NA	Clinicians provided medication tissue plasminogen activator timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the EHRs contained documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• None of the employees had completed the web-based training required by the facility.
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were collected and reported to VHA: 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

9. 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.

10. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

12. We recommended that the facility collect and report to VHA 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 (2 residents receiving restorative nursing services and 10 residents not receiving restorative nursing services but candidates for services). We also observed 5 residents during 2 meal periods, reviewed 10 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 44 employees (29 randomly selected Level 1 ancillary staff and 15 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas—one at the Leavenworth division and one at the Topeka 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 emergency drills were not conducted in the MRI areas.
X	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.	• Fourteen EHRs (40 percent) did not contain initial patient safety screenings.
X	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.	• Twenty of the 31 applicable EHRs (65 percent) did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• Seventeen Level 1 ancillary staff did not receive level-specific annual MRI safety training.
X	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	• The Leavenworth division had no signage to indicate restriction to Zone III. • At the Leavenworth division, Zone III was not adequately protected to prohibit unauthorized access.
	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.	

NM	Areas Reviewed (continued)	Findings
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
X	The facility complied with any additional elements required by VHA or local policy.	• The Leavenworth division's MRI area had potential risks with electrical safety, tripping hazards, and unsecured access to the phone and information technology systems.

Recommendations

13. We recommended that processes be strengthened to ensure that contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan 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.

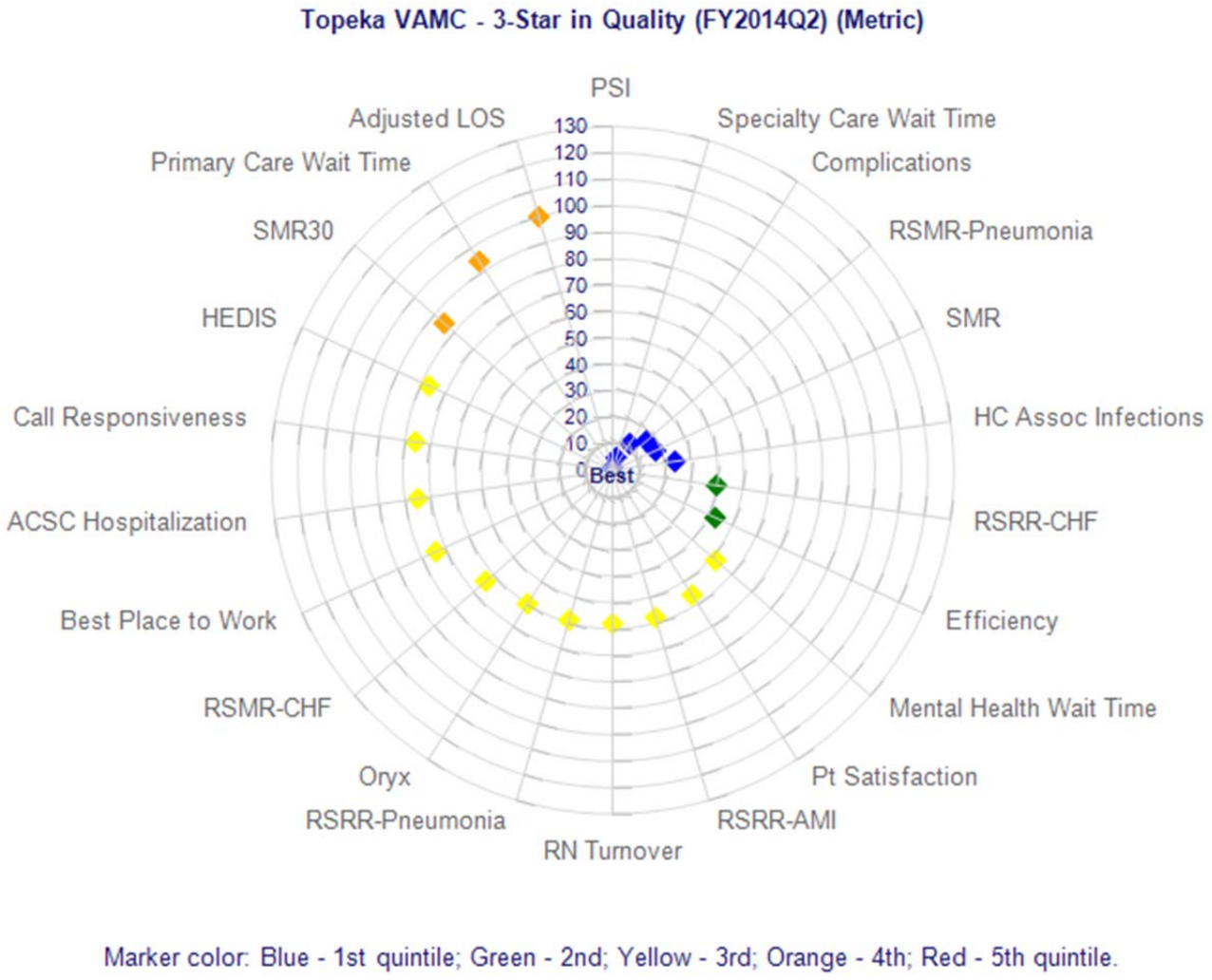
17. We recommended that appropriate signage and barriers be in place at the Leavenworth division to restrict access to magnetic resonance imaging Zone III.

18. We recommended that the Magnetic Resonance Imaging Safety Committee and the Patient Safety Manager evaluate the identified potential safety and security risks and take appropriate actions.

Facility Profile (Topeka/589A5) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$277
Number of:	
• **Unique Patients**	30,671
• **Outpatient Visits**	281,774
• **Unique Employees**[2]	1,784
Type and Number of Operating Beds:	
• **Hospital**	196
• **CLC**	138
• **MH**	202
Average Daily Census (as of May 2014):	
• **Hospital**	76
• **CLC**	52
• **MH**	160
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	St. Joseph/589GI Wyandotte/589GJ Chanute/589GM Emporia/589GN Garnett/589GP Junction City/589GR Seneca/589GT Lawrence/589GU Ft. Scott/589GV
VISN Number	15

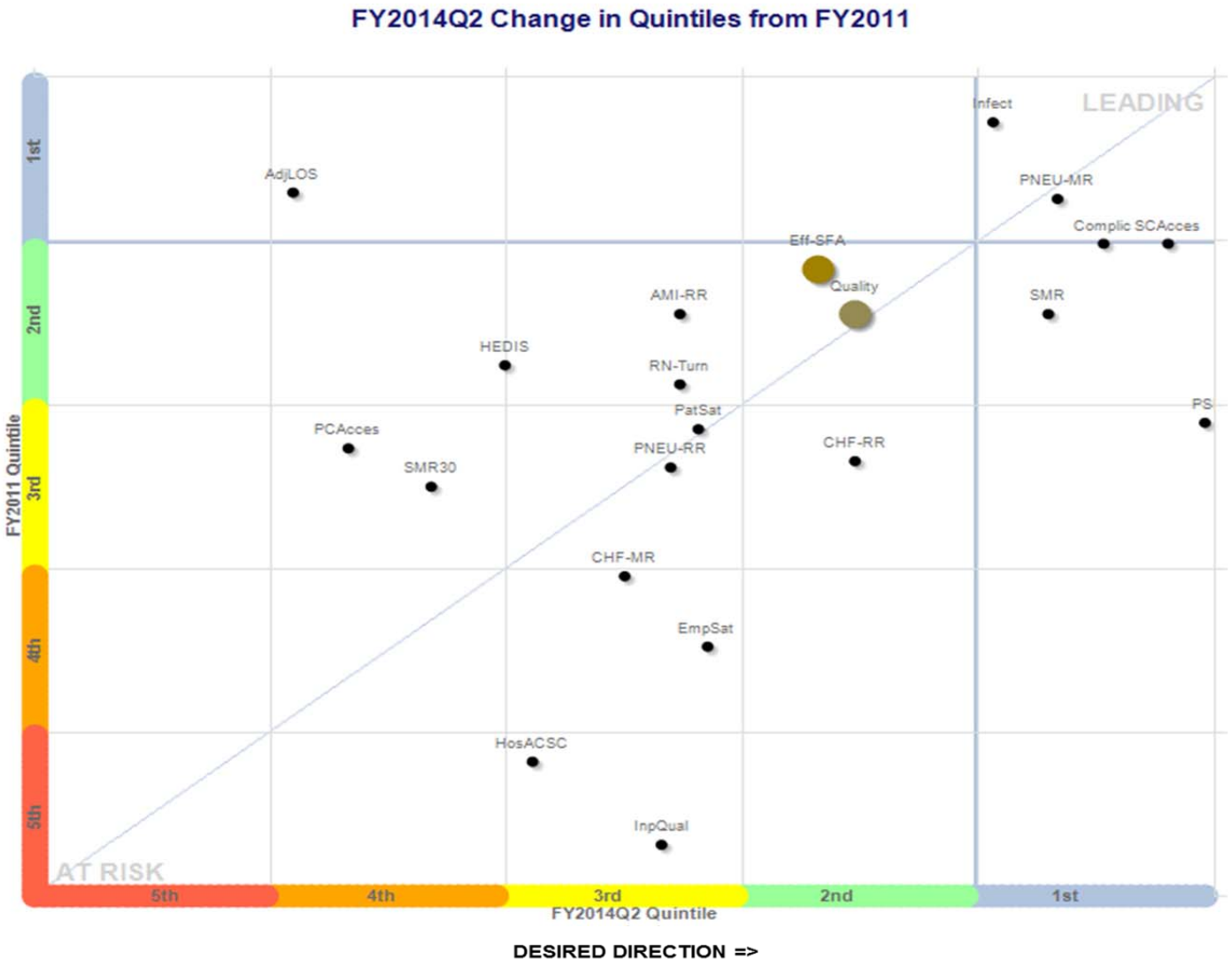
[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
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; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 24, 2014

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the VA Eastern Kansas Health Care System, Topeka, KS**

To: Director, Kansas City Regional 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 VA Eastern Kansas Health Care System, Topeka KS (Conducted the week of June 9, 2014).

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity to focus on continuous performance improvement.

For additional questions, please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at 816-701-3000.

(*original signed by:)*
WILLIAM P. PATTERSON, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 21, 2014

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

Subject: **CAP Review of the VA Eastern Kansas Health Care System, Topeka, KS**

To: Director, VA Heartland Network (10N15)

I appreciate the OIG's comprehensive report and efforts to ensure high quality of care for our Veterans. Eastern Kansas is in concurrence with the report.

(original signed by:)
A RUDY KLOPFER, FACHE, VHA-CM

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 processes be strengthened to ensure that actions from peer reviews are consistently completed and reported to the Peer Review Committee.

Concur

Target date for completion: October 31, 2014

Facility response: New action format for all Level 2s and 3s has been implemented. Cases will be monitored until all actions are completed. Actions and completion dates are now reported to the Peer Review Committee on a monthly basis. Seventy percent of all Level 2 and 3 cases will be audited until 3 consecutive months of 90 percent or greater compliance is maintained. After 3 consecutive months of compliance the Peer Review Committee will determine perimeters for continued audits to ensure maintained compliance with actions being completed and results reported. The Medical Executive Board will receive a quarterly report on all OIG findings follow-up.

Recommendation 2. We recommended that the Peer Review Committee consistently submit quarterly summary reports to the Medical Executive Committee.

Concur

Target date for completion: January 31, 2015

Facility response: Quarterly summary reports will be submitted to the Medical Executive Board. The Risk Manager will be in attendance to discuss reports. Medical Executive Board minutes will document activity.

Recommendation 3. We recommended that the Surgical Work Group meet monthly and consistently document its review of National Surgical Office reports.

Concur

Target date for completion: January 31, 2015

Facility response: Surgical Service Workgroup will meet monthly. The "tracking log" will be implemented July 21, 2014. Medical Executive Board will monitor compliance. The meeting minutes template has been changed to include a section to include information and reports for VA Surgical Quality Improvement Program and other national reports.

Recommendation 4. We recommended that processes be strengthened to ensure that data from electronic health record quality reviews are analyzed at least quarterly.

Concur

Target date for completion: April 30, 2015

Facility response: The Medical Records Committee will meet on a quarterly basis. Items from the agenda that cannot be voted on, due to lack of a quorum will be sent out to the Medical Records Committee members via email for approval. Medical Executive Board will monitor compliance.

Recommendation 5. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

Concur

Target date for completion: February 27, 2015

Facility response: The Document Scanning Health System Policy Memoranda will be revised to add that documents are date stamped when scanned into Computerized Patient Record System (CPRS). Seventy-five scanned documents will be monitored monthly to ensure compliance. Compliance will be monitored in the Medical Records Committee. Audits will be completed until 90 percent compliance is reached for 6 months with 3 consecutive month's compliance. The Medical Records Committee will determine perimeters for continued audits to evaluate continued and ongoing compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that the Tissue and Transfusion Committee member from Anesthesia Service consistently attends meetings.

Concur

Target date for completion: January 31, 2015

Facility response: Anesthesiology has designated an official member to attend the Tissue and Transfusion Committee. In their absence, a representative from Anesthesia will attend the meeting. Tissue and Transfusion Committee will monitor compliance and elevate to Medical Executive Board if attendance continues to be an issue.

Recommendation 7. We recommended that processes be strengthened to ensure that damaged optical examination chairs in the eye clinics are repaired or removed from service.

Concur

Target date for completion: January 31, 2015

Facility response: Chairs in the eye clinic will either be repaired or replaced. Currently chairs are being evaluated to determine if repair is an option. Until chair arms are replaced or repaired, bio-med will provide a covering that will allow cleaning between patient uses.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that compliance be monitored.

Concur

Target date for completion: March 15, 2015

Facility response: Barriers to learning must be identified and documented upon admission and at the time of discharge. This documentation must include the strategies implemented to overcome the identified barriers. All learning barriers identified upon admission must be addressed at the time of discharge to ensure patients understand all discharge instructions. Templates used by nursing and pharmacy staff to document learning assessments at the time of admission and discharge will be updated to include a required field for documenting strategies used to address identified barriers:

- EK-IPAA 3 NURSING ADMISSION SCREEN
- EK-PATIENT EDUCATION
- EK-NURSING DISCHARGE SUMMARY
- EK-PHARMACY DISCHARGE COUNSELING
- EK-PHARMACY MEDICATION COUNSELING
- EK-PHARMACY MEDICATION COUNSELING (BP-L)
- EK-PHARMACY MEDICATION REVIEW (BP)

Nursing and pharmacy staff will receive education regarding the updated templates. To determine compliance, Pharmacy Service will audit 60 inpatient charts on a monthly basis for at least 6 months with 90 percent compliance being maintained for 3 consecutive months. Ongoing audit requirements will be determined through Pharmacy Service to ensure maintained compliance. The results of the audits will be communicated to Nursing Service and Medicine Service, facilitating collaboration between Pharmacy, Nursing, and Medicine Services to ensure that patients and/or caregivers understand instructions provided upon discharge, with that understanding documented in the patients' electronic health records. Pharmacy Service will provide a monthly report to the Readiness Committee.

Recommendation 9. 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: January 31, 2015

Facility response: Information instructing staff on how to complete the National Institutes of Health Scales is in the Hospitalist Manual, additionally the scale is detailed on the acute ischemic stroke algorithm that is posted in every acute unit. Also National Institutes Health Scales information is included in the Health System Policy Monitor (HSPM). A memo was sent out to all acute staff providers about the required use of the National Institutes Health Scales with acute ischemic stroke patients. Audits will be performed on 30 percent of patients with an acute stroke for at least 6 months and until 3 consecutive months of 90 percent compliance is achieved and maintained. Compliance reports will be tracked through the Emergency Room Committee on a monthly basis; also they will be responsible for assigning additional audits to ensure that compliance is maintained past the initial auditing period.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: An automatic order drops into Computerized Patient Record System (CPRS) when the discharge documentation is completed by the provider. This order instructs staff to provide the appropriate information/educational handouts to the patient and/or family. Task completion of stroke education being provided to the Veteran and/or family will be documented in the medical record. Audits will be performed on 30 percent of discharged acute stroke patients for at least 6 months and until 3 consecutive months of 90 percent compliance is achieved and maintained. Compliance reports will be tracked through the Emergency Room and Intensive Care Unit/Progressive Care Unit Committees; with additional audits assigned through the Emergency Room Committee to ensure ongoing compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that staff who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: January 31, 2015

Facility response: Staff has been assigned web-based training and new staff will be assigned training as appropriate. Medicine Office will track compliance of medical staff and Nursing Service will monitor compliance of nursing staff; reports will go to the Emergency Room and Intensive Care Unit/Progressive Care Unit Committees for oversight on a quarterly basis.

Recommendation 12. We recommended that the facility collect and report to VHA 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: January 31, 2015

Facility response: VA Eastern Kansas will collect and report to the Veterans Health Administration the percent of patients with stroke symptoms who had the stroke scale and the percent of patients screened for difficulty swallowing before oral intake per Veterans Health Administration Directives. Compliance will be monitored in the Emergency Room and Intensive Care Unit/Progressive Care Unit Committees.

Recommendation 13. We recommended that processes be strengthened to ensure that contrast reaction emergency drills are conducted in magnetic resonance imaging and that compliance be monitored.

Concur

Target date for completion: January 1, 2015

Facility response: Coordination with Education and Safety Departments is in process to schedule contrast reaction emergency drills. Drills will be performed annually with results provided to Magnetic Resonance Imaging Safety Committee. The Magnetic Resonance Imaging Safety Committee will monitor compliance.

Recommendation 14. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: January 1, 2015

Facility response: Instruction was provided to physicians that both a consult and a request must to be entered for all magnetic resonance imaging examinations. The magnetic resonance imaging consult contains initial safety screening questions and this will ensure that the screening is documented into the patient's electronic medical record. Fifty magnetic resonance imaging examination audits will be completed on a monthly basis for 6 months and until 90 percent compliance is maintained for 3 consecutive months; further audits will be assigned by the Magnetic Resonance Imaging Safety

Committee to ensure compliance is being maintained. Magnetic Resonance Imaging Safety Committee will monitor audit results and ongoing compliance.

Recommendation 15. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: November 30, 2014

Facility response: A new Computerized Patient Record System Template was created titled "MRI Safety Note". A memorandum was sent to all magnetic resonance imaging staff notifying of the new template and requirement for use. MRI Safety Notes will be entered into Computerized Patient Record System for every magnetic resonance imaging patient according to Veterans Health Administration Handbook 1105.05. Fifty magnetic resonance imaging audits will be completed on a monthly basis for 6 months and until 90 percent compliance is maintained for 3 consecutive months; further audits will be assigned by the Magnetic Resonance Imaging Safety Committee to ensure compliance is being maintained. The Magnetic Resonance Imaging Safety Committee will monitor audit results and ongoing compliance.

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: November 30, 2014

Facility response: Training has been assigned to those required who have not yet received it. The Chief Technologist will monitor compliance with completion of Magnetic Resonance Imaging Level 1 Safety Training monthly and will report the results to the Magnetic Resonance Imaging Safety Committee on a quarterly basis.

Recommendation 17. We recommended that appropriate signage and barriers be in place at the Leavenworth division to restrict access to magnetic resonance imaging Zone III.

Concur

Target date for completion: June 30, 2014

Facility response: Signs were ordered and applied to Zone III access areas. Stanchion posts and chains were placed to restrict access to magnetic resonance imaging trailer.

Recommendation 18. We recommended that the Magnetic Resonance Imaging Safety Committee and the Patient Safety Manager evaluate the identified potential safety and security risks and take appropriate actions.

Concur

Target date for completion: January 1, 2015

Facility response: An engineering and safety team met with the Chief Technologist and came up with a plan to address the identified potential safety and security risks. A deeper box to house the phone and data cables will be installed with a knock-out at the bottom so that the front cover will be able to completely close while the cables are plugged in. This will eliminate the exposed cable plugs during operation. A cable mat has been ordered to cover the cables on the ground. The Patient Safety Manager has reviewed and concurred with the responses of the OIG related to magnetic resonance imaging safety. Additionally, the Patient Safety Manager is a member of the Magnetic Resonance Safety Committee and will discuss the policy regarding safety incident reporting at the Post OIG Magnetic Resonance Imaging Safety Committee meeting scheduled for July 28, 2014; this will ensure that all members of the committee have a clear understanding of what constitutes an incident and when reporting is required. After installation of the cable box and cable mat, the Patient Safety Manager, Chief Technologist and engineering team will inspect the area to determine compliance and report results to the Magnetic Resonance Imaging Safety Committee.

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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 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
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- 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:
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- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
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- 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:
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- 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:
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- 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.
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