Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04213-115

Combined Assessment Program Review of the Tomah VA Medical Center Tomah, Wisconsin

February 12, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Tomah VA Medical Center
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration

Table of Contents

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, and to provide crime awareness briefings. We conducted the review the week of October 20, 2014.

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

- Coordination of Care
- Magnetic Resonance Imaging Safety
- Emergency Airway Management
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishments were opening two of four planned Green House homes in September 2014 and receiving the VA National Center for Patient Safety's Gold Cornerstone Award for fiscal year 2013.

Recommendations: We made recommendations in the following three activities:

Quality Management: Ensure the Emergency Services Committee physician member consistently attends meetings and participates in code reviews. Require the Safe Patient Handling Committee to track patient handling injury data. Ensure the Medical Record Committee includes physician documentation in the review of electronic health record quality. Include all required elements in the quality control policy for scanning.

Environment of Care: Repair damaged furniture in patient care areas, or remove it from service. Store clean and dirty items separately. Secure medications at all times. Conduct and document annual complete system checks of the community living center's elopement prevention system.

Medication Management: Ensure staff use special medication labeling for look-alike and sound-alike medications. Require the high-alert/hazardous medication list to be available for staff reference on the acute medicine unit and both community living center units. Ensure nursing staff review monthly inspections of nursing station medication areas.

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 24–29, 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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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
- MRI Safety
- EAM
- MH RRTP

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, FY 2014, and FY 2015 through October 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 Tomah VA Medical Center, Tomah, Wisconsin,* Report No. 12-01337-267, September 5, 2012.

During this review, we presented crime awareness briefings for 67 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 288 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

Green House Homes

In September 2014, the facility opened up the first two of four planned Green House homes. Green House homes represent a new and innovative concept in long-term care. The Patriots' Place and Heroes' House homes will allow 20 residents the opportunity to independently direct their care and treatment on their own schedules while living in state-of-the-art accommodations. Each home is staffed by a nurse and two resident care assistants on each shift who provide patient care, cooking/light housekeeping, and assistance with various activities. In addition, medical providers, nurses, social workers, and dieticians make up a clinical support team to assist with meeting residents' medical needs.

Cornerstone Recognition Program

The VA National Center for Patient Safety initiated the Cornerstone Recognition Program in 2008 to enhance the root cause analysis process and recognize the accomplishments of patient safety at the facility level. The facility received the Gold Cornerstone Award for FY 2013.

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, 12 credentialing and privileging folders, 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	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.		
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.	Eleven months of Emergency Services Committee meeting minutes reviewed: • The physician chairperson did not attend 10 months of meetings, and there was no evidence of physician participation in code episode review.	**1.** We recommended that the facility ensure that the Emergency Services Committee physician member consistently attends meetings and participates in code reviews.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
NA	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	Four quarters of Safe Patient Handling Committee meeting minutes reviewed: • The committee did not track patient handling injury data.	**2.** We recommended that the Safe Patient Handling Committee track patient handling injury data.
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Eleven months of Medical Record Committee meeting minutes reviewed: • The review of EHR quality did not include physician documentation.	**3.** We recommended that the Medical Record Committee include physician documentation in the review of electronic health record quality.
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy did not include: o The quality of the source document o An alternative means of capturing data when the quality of the source document does not meet image quality controls o A complete review of scanned documents to ensure readability and retrievability	**4.** We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure readability and retrievability, and quality assurance reviews on a sample of the scanned documents.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.	o Quality assurance reviews on a sample of the scanned documents	
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		

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. We also determined whether the facility met selected requirements in the CLC.[b]

We inspected the urgent care clinic; the primary care red team; and the acute MH, acute medicine, and inpatient rehabilitation units. We also inspected the CLC Country Inn and Whispering Pines units. Additionally, we reviewed relevant documents and 24 CLC employee training records and conversed with key employees and managers. 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 for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment and implemented actions 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.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Two of five patient care areas contained damaged furniture.	**5.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met infection prevention requirements.	• Three of five patient care areas had clean and dirty items stored together.	**6.** We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.
X	The facility met medication safety and security requirements.	• One of five patient care areas contained unsecured medications.	**7.** We recommended that facility managers ensure medications are secured at all times and monitor compliance.
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
NA	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
NA	The facility had an inventory of alarm-equipped medical devices used in high-risk areas and for high-risk clinical conditions and inspected/checked this equipment according to local policy and/or manufacturers' recommendations.		
NA	The facility met fire safety requirements in critical care.		
NA	The facility met environmental safety requirements in critical care.		
NA	The facility met infection prevention requirements in critical care.		
NA	The facility met medication safety and security requirements in critical care.		
NA	The facility met medical equipment requirements in critical care.		
NA	The facility met privacy requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
NA	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not have evidence of an annual complete system check of the CLC elopement prevention system.	**8.** We recommended that the facility conduct and document annual complete system checks of the community living center's elopement prevention system and that facility managers monitor compliance.
	The facility met fire safety requirements in the CLC.		
X	The facility met environmental safety requirements in the CLC.	• One of two units contained damaged furniture.	See recommendation 5.
X	The facility met infection prevention requirements in the CLC.	• In one of two units, dirty and clean equipment items were stored in the same storage room.	See recommendation 6.
X	The facility met medication safety and security requirements in the CLC.	• One of two units contained unsecured medications.	See recommendation 7.
NA	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the urgent care clinic, the acute medicine unit, and two CLC units and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. 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	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.	• The facility did not use special medication labeling for look-alike and sound-alike medications on the acute medicine and CLC units.	**9.** We recommended that the facility use special medication labeling for look-alike and sound-alike medications and that facility managers monitor compliance.
X	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.	• The facility's high-alert/hazardous medication list was not available for staff reference on the acute medicine and CLC units.	**10.** We recommended that the facility ensure the high-alert/hazardous medication list is available for staff reference on the acute medicine unit and both community living center units.
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
	Pharmacy had a written plan for safe use of automated dispensing machines that included oversight of overrides and minimum competency requirements for employees who have access to and operate them, and employees received training with the frequency required by local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
NA	The facility met multi-dose insulin pen requirements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on pharmacy nursing station reviews assessed: • There was no documentation that nursing staff reviewed the monthly inspections of nursing station medication areas.	**11.** We recommended that the facility ensure nursing staff review monthly inspections of nursing station medication areas.

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 30 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. 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	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors properly titled the requests. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
NA	The facility met 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.[e]

We reviewed relevant documents and the training records of six Level 1 ancillary staff, 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. Effective October 1, 2014, the facility transferred MRI services to Non-VA Care Coordination. Consequently, the facility will no longer offer onsite MRI services.

The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Eighteen of the 24 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	Because the facility no longer offers onsite MRI services, we made no recommendation.
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
NA	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
NA	The facility provided patients with MRI-safe hearing protection for use during the scan.		
NA	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[f]

We reviewed relevant documents and conversed with key managers and 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	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
NA	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
NA	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
NA	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
NA	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
NA	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
NA	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

The purpose of this review was to determine whether the facility's Substance Abuse and Post-Traumatic Stress Disorder RRTPs complied with selected EOC requirements.[7]

We reviewed relevant documents, inspected the Substance Abuse and Post-Traumatic Stress Disorder RRTPs, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to the facility are marked NA. The facility generally met requirements. We made no recommendations.

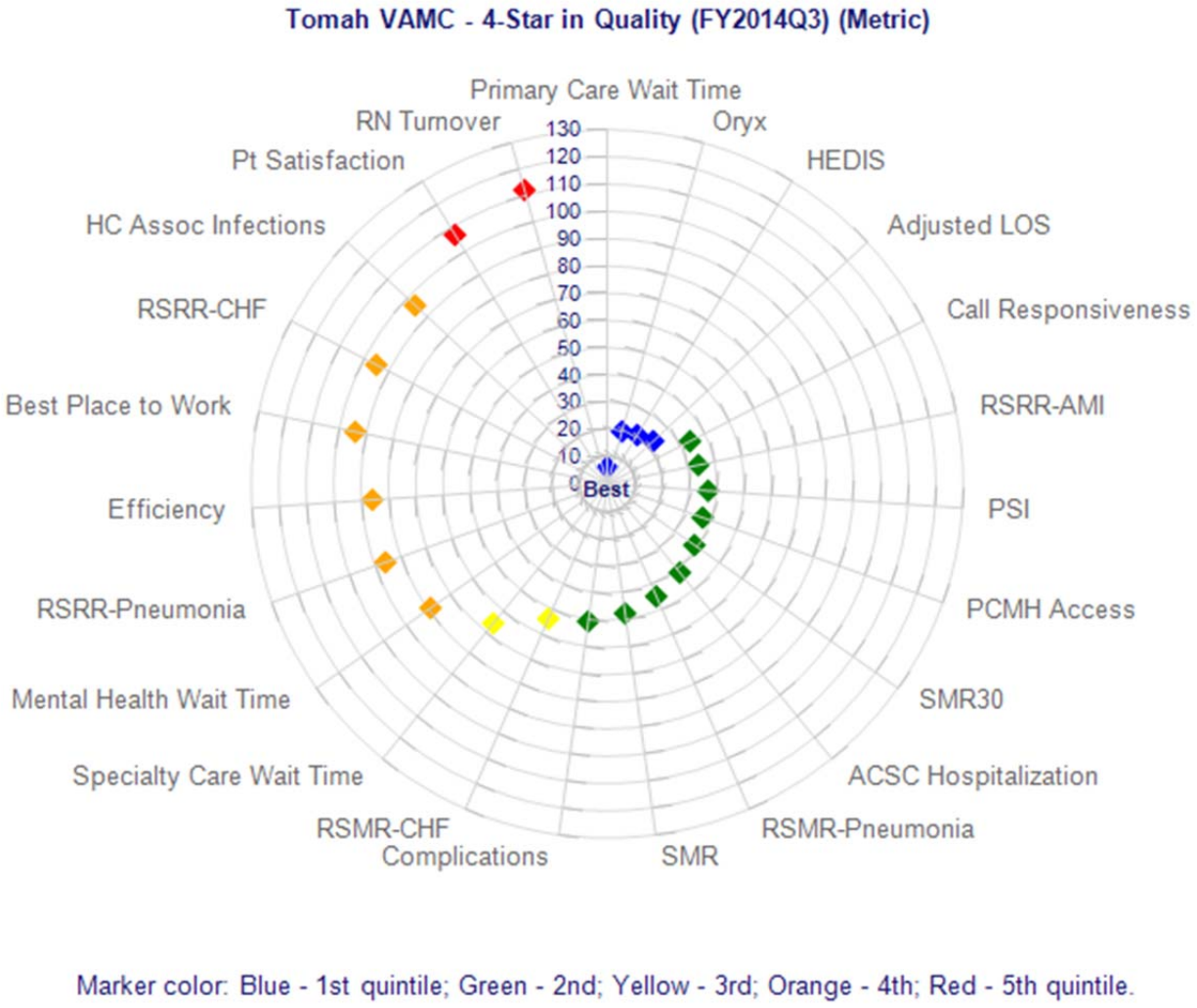
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Tomah/676) FY 2014[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$147.2
Number of:	
• **Unique Patients**	25,877
• **Outpatient Visits**	261,187
• **Unique Employees**[2]	906
Type and Number of Operating Beds (as of August 2014):	
• **Hospital**	17
• **CLC**	200
• **MH**	35
Average Daily Census (as of August 2014):	
• **Hospital**	11
• **CLC**	162
• **MH**	29
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Wausau/676GA La Crosse/676GC Wisconsin Rapids/676GD Clark County/676GE
Veterans Integrated Service Network Number	12

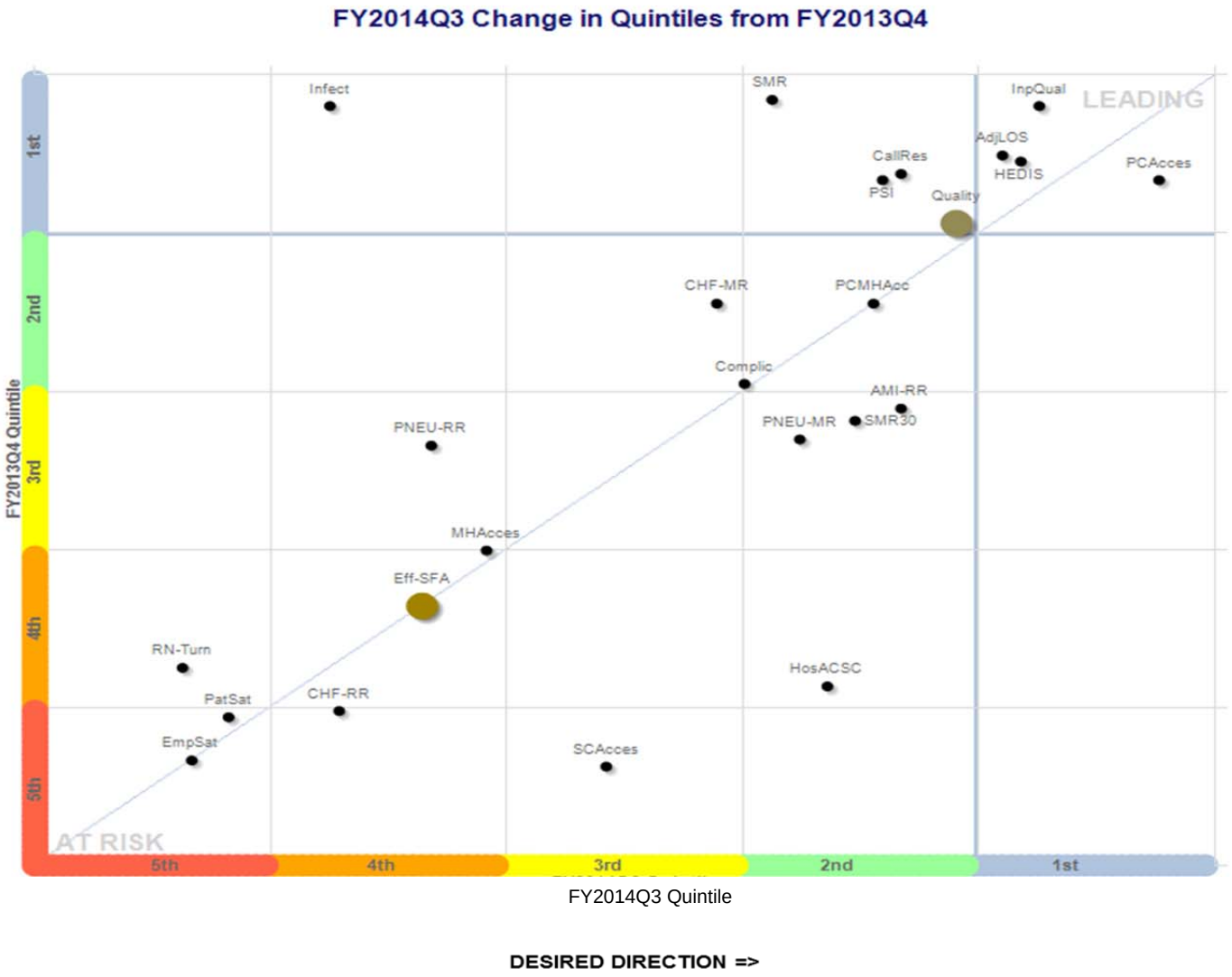
[1] All data is for the entire FY 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 29, 2014

From: Director, VA Great Lakes Health Care System (10N12)

Subject: **CAP Review of the Tomah VA Medical Center, Tomah, WI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

1. Attached please find the CAP Review response to the draft report from the Tomah VA Medical Center, Tomah, WI review.
2. I have reviewed the completed response.
3. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at the Tomah VAMC.

Renee Oshinski

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 29, 2014

From: Director, Tomah VA Medical Center (676/00)

Subject: **CAP Review of the Tomah VA Medical Center, Tomah, WI**

To: Director, VA Great Lakes Health Care System (10N12)

Thank you for the opportunity to view the draft report of the Tomah Veterans Affairs Medical Center inspection. I have reviewed the document and concur with the recommendations.

Corrective action plans have been established with planned completion dates, as detailed in the attached report. If additional information is needed please contact my office at (608) 372-1777.

Mario V. DeSanctis, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility ensure that the Emergency Services Committee physician member consistently attends meetings and participates in code reviews.

Concur

Target date for completion: April 30, 2015

Facility response: The Chief, Medicine Service will appoint a physician member to attend the Emergency Services Committee (ESC) and review each code episode. Attendance will be reflected in the ESC meeting minutes. Monitoring will continue until at least 90 percent compliance with attendance is obtained.

Recommendation 2. We recommended that the Safe Patient Handling Committee track patient handling injury data.

Concur

Target date for completion: June 30, 2015

Facility response: The Safe Patient Handling Committee (SPHC) will track patient handling injury data. This will be reflected in the SPHC quarterly meeting minutes. Monitoring will continue until at least 90 percent compliance is obtained.

Recommendation 3. We recommended that the Medical Record Committee include physician documentation in the review of electronic health record quality.

Concur

Target date for completion: June 30, 2015

Facility response: The Chief, Health Information Management Section (HIMS) will include physician documentation in the review of electronic health record quality. This will be reported to the Medical Record Committee on a quarterly basis.

Recommendation 4. We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete

review of scanned documents to ensure readability and retrievability, and quality assurance reviews on a sample of the scanned documents.

Concur

Target date for completion: April 30, 2015

Facility response: The Chief, Health Information Management Section (HIMS) will update the scanning policy for the Tomah VAMC and include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure readability, retrievability, and a quality assurance process. The Chief, HIMS will provide 100 scanning audits per month to the Medical Record Committee. Monitoring will continue until at least 90 percent compliance with audits is obtained.

Recommendation 5. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: June 30, 2015

Facility response: Environmental Management Services will conduct a sweep of patient care areas and send all damaged furniture for repair or replacement. During monthly Environment of Care rounds staff will identify damaged furniture in patient care areas and send it for repair or replacement. This will be tracked through the Environment of Care Committee. Monitoring will continue until at least 90 percent compliance is obtained.

Recommendation 6. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Tomah VAMC staff will be educated on the process to identify clean equipment with a clear plastic bag and ensure these items are not stored with dirty equipment. Nursing Management will audit this during monthly Environment of Care rounds. This will be tracked through the Environment of Care Committee. Monitoring will continue until at least 90 percent compliance with audits is obtained.

Recommendation 7. We recommended that facility managers ensure that medications are secured at all times and monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Tomah VAMC licensed nursing staff will be educated on the process to ensure medications are secured at all times. Nursing Management will audit this during monthly Environment of Care rounds. This will be tracked through the Environment of Care Committee. Monitoring will continue until at least 90 percent compliance with audits is obtained.

Recommendation 8. We recommended that the facility conduct and document annual complete system checks of the community living center's elopement prevention system and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2015

Facility response: Biomedical Engineering will conduct and document annual complete system checks of the community living center's elopement prevention system. This will be reported through the Environment of Care Committee. Monitoring will continue until at least 90 percent compliance is obtained.

Recommendation 9. We recommended that the facility use special medication labeling for look-alike and sound-alike medications and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2015

Facility response: Pharmacy will update the Omnicell Automated drug dispensing cabinets to include TALLMAN lettering for look-alike and sound-alike medications. Any changes to the drug formulary or updates to the cabinets will have a review by Pharmacy Management for the inclusion of TALLMAN lettering. This will be reported to the Pharmacy and Therapeutics Committee to reflect completion of this new labeling process.

Recommendation 10. We recommended that the facility ensure the high-alert/hazardous medication list is available for staff reference on the acute medicine unit and both community living center units.

Concur

Target date for completion: April 30, 2015

Facility response: Nursing Management will mount high-alert/hazardous medication lists by all medication stations. Nursing Management will audit this during monthly Environment of Care rounds. This will be tracked through the Environment of Care Committee. Monitoring will continue until at least 90 percent compliance with audits is obtained.

Recommendation 11. We recommended that the facility ensure nursing staff review monthly inspections of nursing station medication areas.

Concur

Target date for completion: June 30, 2015

Facility response: Nursing staff will review all monthly inspections of nursing station medication areas. Pharmacy Management will monitor this process to ensure at least 90 percent of inspections are reviewed by nursing staff.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Wachita Haywood, RN, Team Leader Lisa Barnes, MSW Debra Boyd-Seale, RN, PhD Alicia Castillo-Flores, MBA, MPH Roberta Thompson, LCSW Julie Watrous, RN, MS Gregg Hirstein, Special Agent in Charge, Central Field Office of Investigations
Other Contributors	Judy Brown Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Sheila Cooley, GNP, MSN Marnette Dhooghe, MS Patrick Smith, M. Stat Jarvis Yu, MS

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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, 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 Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] 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.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[7] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.