Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04223-100

Combined Assessment Program Review of the VA North Texas Health Care System Dallas, Texas

February 5, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AIM	analytics and information management
AIS	acute ischemic stroke
CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA North Texas Health Care System
FY	fiscal year
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 December 1, 2014.

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

- Environment of Care
- Coordination of Care

The facility's reported accomplishment was the development of the Analytics and Information Management Center.

Recommendations: We made recommendations in the following six activities:

Quality Management: Require that the Executive Quality, Safety, and Value Committee continues to meet and ensures that aggregated data is reviewed, that problems or opportunities for improvement are identified, that specific actions are documented, and that actions are fully implemented and monitored over time. When cases receive initial Level 2 or 3 ratings, require the Peer Review Committee to consistently invite involved providers to submit comments to and/or appear before the committee. Ensure that the Critical Care Committee reviews each code episode and consistently collects code data and that code reviews include screening for clinical issues prior to the code. Require the Surgical Work Group to meet monthly and to review all surgical deaths with identified problems or opportunities for improvement. Include all required elements in the quality control policy for scanning.

Medication Management: Revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users.

Magnetic Resonance Imaging Safety: Conduct contrast reaction drills in the magnetic resonance imaging area. Conduct initial patient safety screenings. Document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan. Ensure all designated Level 1 ancillary staff and all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training.

Acute Ischemic Stroke Care: Implement a stroke care designation appropriate to the inpatient acute care complexity. Develop and implement an acute ischemic stroke policy that addresses all required items. Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines in all required

areas. Provide printed stroke education to patients upon discharge. Provide an employee stroke education program. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Ensure applicable Nursing Service employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and have competency assessment and validation completed and documented. Require that post-anesthesia care competency assessment and validation is completed for intensive care unit employees.

Emergency Airway Management: Ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of scopes of practice and includes all required elements.

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 26–34, 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
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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 eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- AIS Care
- Surgical Complexity
- EAM

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 December 5, 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 North Texas Health Care System, Dallas, Texas,* Report No. 12-01874-245, August 13, 2012.

During this review, we presented crime awareness briefings for 698 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 661 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 Accomplishment

AIM Center

In 2014, the facility started the AIM Center, a Microsoft Access data tool that pulls from the Corporate Data Warehouse and a variety of other VA data sources to provide a comprehensive snapshot of the facility's progress towards its strategic goals. AIM is an interactive tool that offers the ability to create custom daily reports, which aids the facility in making proactive and data-driven decisions with real time information. AIM offers a broad view of facility operations and the ability to drill down to individual patient level information and can be tailored to the facility's strategic goal or VHA initiatives. The three primary functions of AIM are quality, safety, and value, which provide various quality metrics such as patient safety, Strategic Analytics for Improvement and Learning, and Six Sigma; access and flow—used to evaluate access of services and clinics; and performance measures—all the measures/metrics being tracked throughout the facility. Over the past several months, the Secretary of Veterans Affairs and the Interim Under Secretary for Health have praised AIM as a facility best practice.

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 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
X	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.	• The Executive Quality, Safety, and Value Committee only met five times during the time period December 2013–November 2014. • The committee did not review aggregated data, consistently identify problems or opportunities for improvement, document specific actions, and fully implement or monitor actions over time.	**1.** We recommended that the Executive Quality, Safety, and Value Committee continue to meet and ensure that aggregated data is reviewed, that problems or opportunities for improvement are identified, that specific actions are documented, and that actions are fully implemented and monitored over time.
X	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.	For the 12-month period May 1, 2013–April 30, 2014: • For several of the death cases that received initial Level 2 or 3 ratings, the Peer Review Committee did not invite involved providers to provide input prior to the final determination.	**2.** We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

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.	Twelve months of Critical Care Committee meeting minutes reviewed: • The committee did not review each episode. • Code reviews did not include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. • The committee did not collect code data.	**3.** We recommended that the Critical Care Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee consistently collect code data.

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met five times over the past 12 months. • The Surgical Work Group did not review several surgical deaths that occurred May 1, 2013–April 30, 2014, and had identified problems or opportunities for improvement.	**4.** We recommended that the Surgical Work Group meet monthly. **5.** We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	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.		
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 an alternative means of capturing data when the quality of the source document does not meet image quality controls nor did it require a complete review of scanned documents to ensure readability and retrievability.	**6.** We recommended that the quality control policy for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls and a complete review of scanned documents to ensure readability and retrievability.

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.		
	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.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

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 critical care and the CLC.[b]

We inspected the 2D200 MH unit, the 4C surgery unit, the Emergency Department, the 5A telemetry unit, the 5C telemetry overflow unit, primary care clinic number 3, the orthopedic clinic, the Bonham primary care clinic 1st floor, the Bonham eye clinic, the thoracic and cardiac care units, CLC-A, CLC-B, and Bonham CLC-B-B and CLC-B-C. Additionally, we reviewed relevant documents, including inspection documentation for 11 alarm-equipped medical devices in critical care, and 50 employee training records (20 critical care and 30 CLC), and we conversed with key employees and managers. 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 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.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those 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.		
	The facility met environmental safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	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		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	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.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or 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 25 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the post-anesthesia care unit, the surgical intensive care unit, 6C medicine, CLC-A, and Bonham CLC-B-B 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 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	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
	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 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 conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include oversight of overrides and employee training and minimum competency requirements for users.	**7.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users and that facility managers monitor compliance.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

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 selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	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) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 65 employees (30 randomly selected Level 1 ancillary staff and 35 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. 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
X	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.	• The facility did not conduct contrast reaction drills in the MRI area.	**8.** We recommended that the facility conduct contrast reaction drills in the magnetic resonance imaging area and that facility managers monitor compliance.
X	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.	• Twenty-three EHRs (66 percent) did not contain initial patient safety screenings.	**9.** We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.
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.	• None of the 28 applicable EHRs contained documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**10.** We recommended 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 facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Twenty Level 1 ancillary staff (67 percent) did not receive level-specific annual MRI safety training. • Seventeen Level 2 MRI personnel (49 percent) did not receive level-specific annual MRI safety training.	**11.** We recommended that the facility ensure all designated Level 1 ancillary staff and all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

AIS Care

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

We reviewed relevant documents and the EHRs of 29 randomly selected patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, two intensive care units, and three acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke care designation was appropriate for its inpatient acute care capabilities, and its stroke policy addressed all required items.	• The facility did not have an appropriate designation for stroke care. • The facility did not have a policy in place that addressed the management of AIS.	**12.** We recommended that the facility implement a stroke care designation appropriate to its inpatient acute care complexity. **13.** We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 19 patients, clinicians did not document evidence of completion of stroke scales.	**14.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
X	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.	• Facility managers had not posted stroke guidelines in the Emergency Department or on the intensive care and acute inpatient care units.	**15.** We recommended that facility managers post stroke guidelines in the Emergency Department and on the intensive care and acute inpatient care units.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 clinicians provided stroke education to the patient/caregiver.	**16.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• The facility did not provide a stroke educational program for employees.	**17.** We recommended that facility managers provide a stroke education program.
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or report the following data to VHA: o Percent of eligible patients given tissue plasminogen activator o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**18.** We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. 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	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Seven of 10 applicable employees did not have 12-lead electrocardiogram competency assessment and validation included in their competency checklists. • Two of 10 applicable employees did not have 12-lead electrocardiogram competency assessment and validation documentation completed. Six of the eight who did had their competency assessment and validation completed within the 45 days preceding our visit. • None of the 10 employees on the intensive care unit had post-anesthesia care competency assessment and validation documented.	**19.** We recommended that facility managers ensure that applicable Nursing Service employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and 12-lead electrocardiogram competency assessment and validation completed and documented. **20.** We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the intensive care unit.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.[h]

We reviewed relevant documents, including competency assessment documentation of 13 clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and employees. 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.

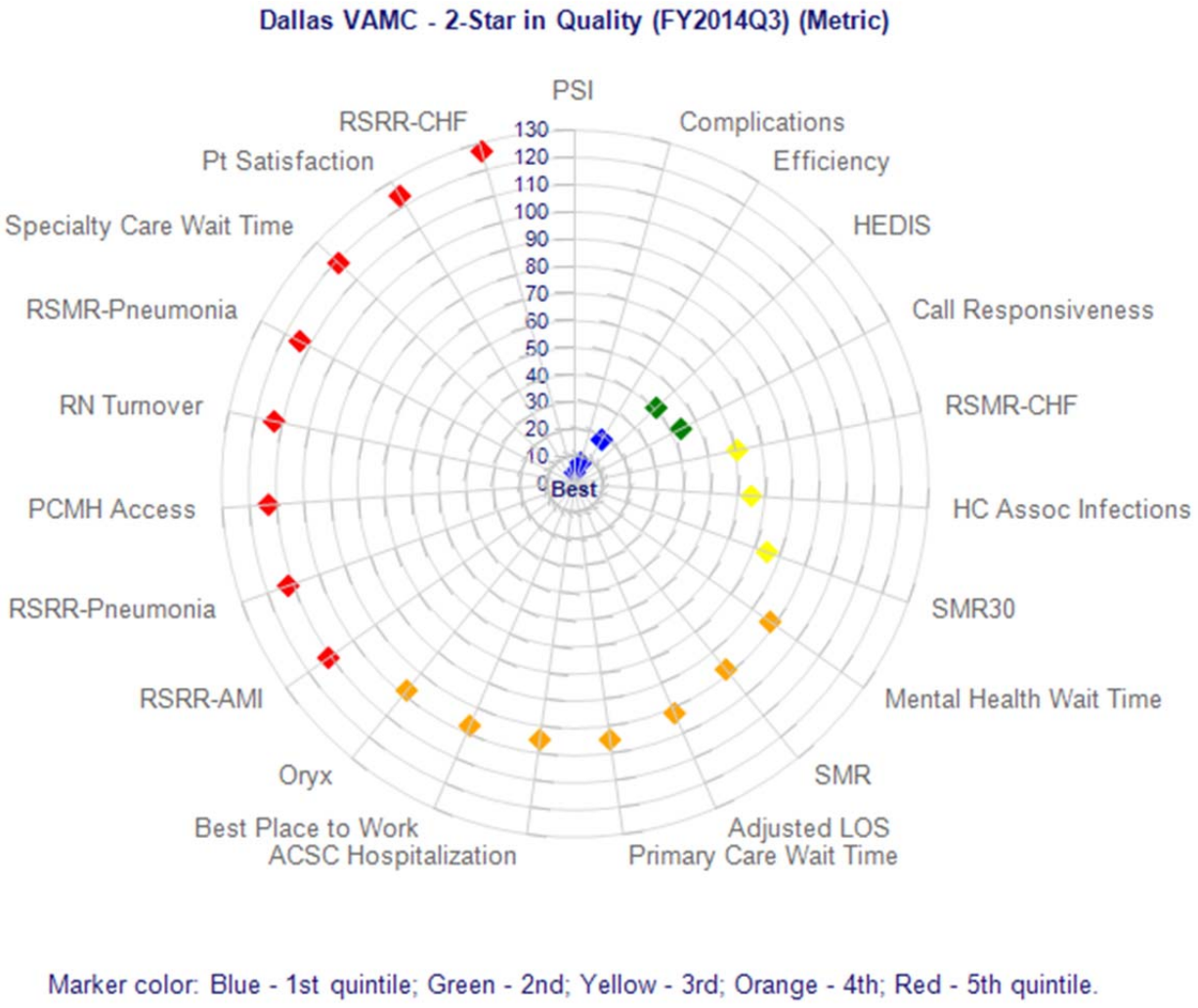
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	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		
	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
X	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	• None of the 13 clinicians had reassessments for continued EAM competency completed at the time of renewal of scopes of practice.	**21.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of scopes of practice and includes all required elements and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Dallas/549) FY 2015 through December 2014[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$794.3
Number of:	
• **Unique Patients**	71,240
• **Outpatient Visits**	253,846
• **Unique Employees**[2]	4,017
Type and Number of Operating Beds (as of November):	
• **Hospital**	276
• **CLC**	240
• **MH**	304
Average Daily Census (as of November):	
• **Hospital**	145
• **CLC**	188
• **MH**	186
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Bonham/549A4 Fort Worth/549BY Tyler/549GA Denton/549GD Bridgeport/549GE Granbury/549GF Greenville/549GH Sherman/549GJ
VISN Number	17

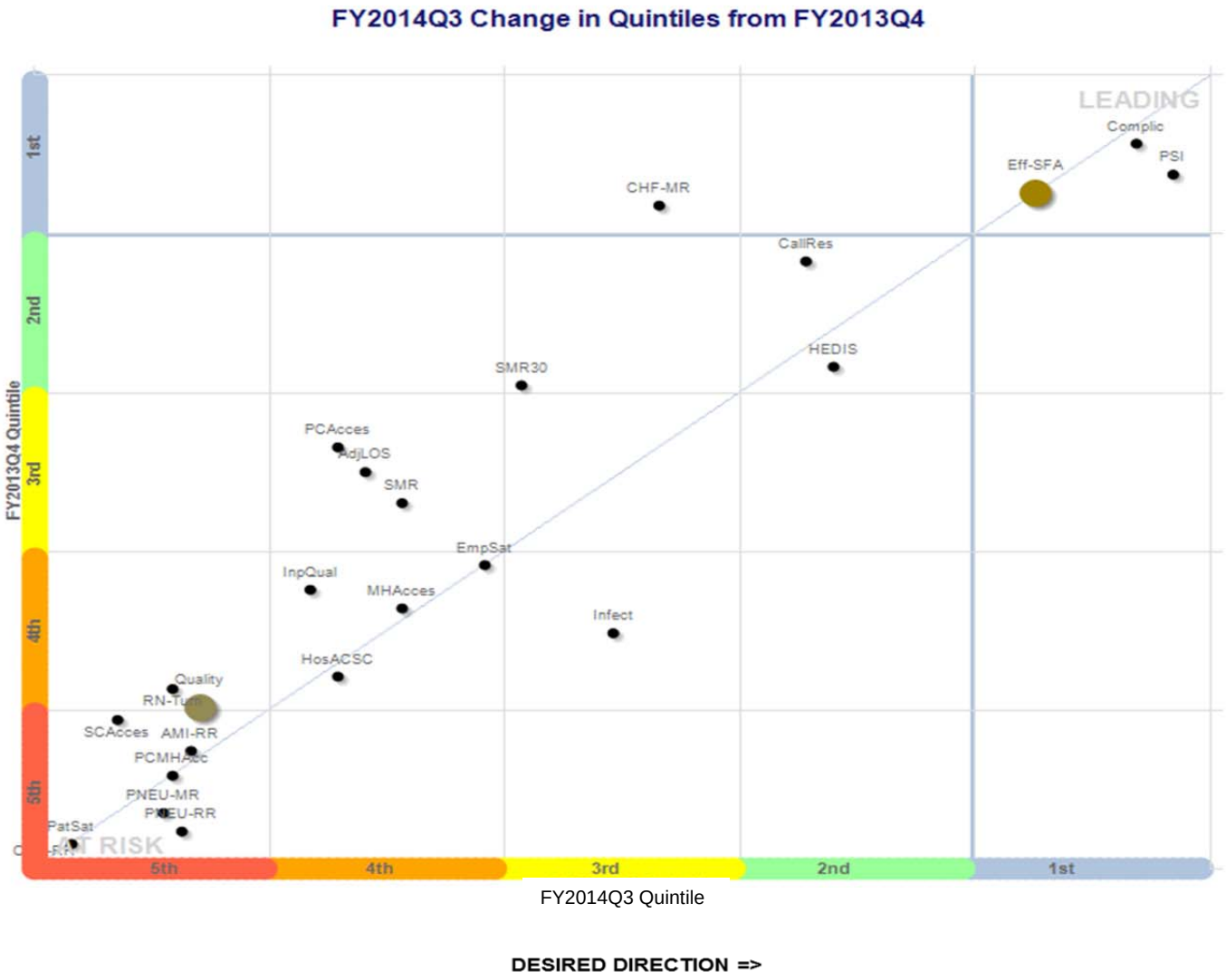
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

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: January 13, 2015

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Review of the VA North Texas Health Care System, Dallas, TX**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

Thank you for allowing me to respond to this CAP Review of the VA North Texas Health Care System, TX.

1. I concur with the recommendations and have ensured that action plans with target dates for completion were developed.

2. If you have further questions regarding this CAP review, please contact Denise B. Elliott, VISN 17 Quality Management Officer at 817-385-3734.

Joseph Dalplaz
Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 12, 2015

From: Director, VA North Texas Health Care System (549/00)

Subject: **CAP Review of the VA North Texas Health Care System, Dallas, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. I have reviewed and concur with the findings in this report. Specific corrective actions have been provided for the recommendations.

2. Should you have any questions, please contact Deanna Boyer, Chief, Quality, Safety & Value at 214-857-0200.

Jeffery L. Milligan
Director

Comments to OIG's Report

OIG Recommendations

Recommendation 1. We recommended that the Executive Quality, Safety, and Value Committee continue to meet and ensure that aggregated data is reviewed, that problems or opportunities for improvement are identified, that specific actions are documented, and that actions are fully implemented and monitored over time.

Concur

Target date for completion: March 31, 2015

Facility response: The Executive Quality, Safety and Value Committee (EQSV) will meet at least 6 times a year, in accordance with their charter. A workgroup will be formed to identify key system measures that will be reported to EQSV. A reporting calendar will be developed to establish reporting times and intervals.

Recommendation 2. We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

Concur

Target date for completion: March 31, 2015

Facility response: The peer review coordinator will document notification to providers of an initial finding of level 2 or 3 within the PRC minutes. Monthly audits of the PRC minutes will be conducted until 90% compliance is met for three consecutive months.

Recommendation 3. We recommended that the Critical Care Committee review each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that the committee consistently collect code data.

Concur

Target date for completion: June 1, 2015

Facility response: The MICU attending review all events within 24 hours. The Critical Care Sub-Committee then reviews each code or cardiac arrest monthly at its quarterly meetings. Factors that could contribute to the incident will be reviewed, and appropriate recommendations made.

Recommendation 4. We recommended that the Surgical Work Group meet monthly.

Concur

Target date for completion: March 31, 2015

Facility response: The Surgical Work Group began meeting monthly. The Group now reviews surgical deaths to identify problems and opportunities for improvement.

Recommendation 5. We recommended that the Surgical Work Group review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: March 31, 2015

Facility response: The Surgical Work Group began meeting monthly. The Group now reviews surgical deaths to identify problems and opportunities for improvement.

Recommendation 6. We recommended that the quality control policy for scanning include an alternative means of capturing data when the quality of the source document does not meet image quality controls and a complete review of scanned documents to ensure readability and retrievability.

Concur

Target date for completion: February 27, 2015

Facility response: VANTHCS policy 001D-03 (Document Scanning Policy) has been updated and is currently in the concurrence cycle. The updated policy now includes alternate means of capturing data when the quality is poor and guidelines for reviewing all documents to ensure quality.

Recommendation 7. We recommended that the facility revise the policy for safe use of automated dispensing machines to include oversight of overrides and employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: February 27, 2015

Facility response: VANTHCS Policy 119-17 (Omnicell Automated Dispensing System) was reviewed and revised to include oversight of overrides and employee training/competency requirements. This policy is currently in the concurrence cycle.

Recommendation 8. We recommended that the facility conduct contrast reaction drills in the magnetic resonance imaging area and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The facilities yearly contrast reaction drill was completed on December 19, 2014. The next drill will be completed in 2015.

Recommendation 9. We recommended that the facility conduct initial patient safety screenings and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: The ordering provider will complete the initial patient screening. Radiology is working with OIT to modify the CPRS order making the initial review a mandatory field.

Recommendation 10. We recommended 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 facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: Imaging personnel will be re-educated on EHR documentation of the resolution to contraindications prior to the scanning. Training will be completed no later than March 2015.

Recommendation 11. We recommended that the facility ensure all designated Level 1 ancillary staff and all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2015

Facility response: All designated Level 1 & 2 ancillary staff will receive level-specific MRI safety training no later than March 2015. Level 1 training has been assigned in TMS by occupational code.

Recommendation 12. We recommended that the facility implement a stroke care designation appropriate to its inpatient acute care complexity.

Concur

Target date for completion: September 30, 2015

Facility response: The facility has created a stroke workgroup who will work through the criteria needed to create a VHA Limited Hours Stroke Facility (VHA LHSF).

- Communication of clearly defined operational hours for the facility LHSF must be completed and communicated to all parties involved—veteran community, EMS, and non-VA Stroke Centers that will receive off-hours patient referrals – 2/27/2015
- EMS agreements and clear understanding of site capabilities, hours of operation and designated site(s) patients are to be transported to when the VA stroke center is not operational – 5/29/2015
- Comprehensive plan in place for diversion or transfer of patients to an appropriate stroke care center capable of administering r-tPA to a patient who is eligible for thrombolytic therapy who arrives after business hours – 5/29/2015
- AIS Treatment Protocols – AIS policy by 6/30/2015
- Outcomes and quality improvement plan for tracking performance 6/30/2015

No later than 6/30/15, the workgroup will submit a stroke center affidavit to the Director to officially implement a stroke care designation appropriate to the facility's inpatient acute care complexity. Once the director approves and signs the stroke center affidavit, then the designation will be submitted to the VISN.

Recommendation 13. We recommended that the facility develop and implement an acute ischemic stroke policy that addresses all required items.

Concur

Target date for completion: September 30, 2015

Facility response: The facility will create and approve a policy for treatment of acute ischemic stroke (AIS) as required by VHA Directive 2011-038 by 3/27/2015. The policy will reflect a VHA LHSF designation.

A stroke workgroup has been created to write this policy. The members include pharmacy representative, chief of emergency medicine, emergency medicine administrative officer, chief nurse of the emergency department, performance measure nurse for medical service, chief of neurology, assistant chief of medical service, chief of

pulmonary/critical care, chief of radiology, chief of pathology, and administrative officer for medical service. To complete the policy:

- A draft policy has been written and is in circulation
- Form the Acute Ischemic Stroke Oversight Committee – 2/6/2015
- Guidelines have been created and will be posted – 2/6/2015
- Create tPA protocol – 2/30/2015
- Augment CPRS template to include NIHSS stroke scale for documentation and tracking of performance – 3/27/2015
- Augment Nursing Education Note to include documentation of patient education – 3/27/2015
- Transfer agreement completed – 5/29/2015
- Patient education – 5/29/2015
- Education program created and implemented – 5/29/2015
- Quality assurance program – awaiting nurse recruitment – 6/30/2015

Policy completed by 6/30/2015.

Recommendation 14. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The facility will complete an educational program on performing the National Institutes of Health Stroke Scale (NIHSS) for all of the Stroke Team by 6/30/2015. A template for stroke in CPRS will be created to include the NIHSS as a required element by 3/27/2015.

Validation of compliance will be collected by the Neurology section and monitored by the NTHCS Stroke Center Oversight Committee (will need to be formed) for a period of not less than 90 days to ensure 90 percent performance. This will be reviewed quarterly.

Recommendation 15. We recommended that facility managers post stroke guidelines in the Emergency Department and on the intensive care and acute inpatient care units.

Concur

Target date for completion: September 30, 2015

Facility response: The stroke workgroup will create and post the facility stroke flowchart for recognition and treatment of AIS according to local policy in the emergency department, intensive care units, and the acute inpatient care units. The workgroup will

work with the education service and nursing education to create these posters. The guidelines have been created and will be posted by 2/6/2015.

Recommendation 16. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Education service will identify select stroke education materials that will be available for Veterans. Educational material will be added to the tools section in CPRS so staff can print and provide to patients on discharge. Reminder dialogue will be added to the Education Note for staff to document the specific handout that was provided to the Veteran/Caregiver.

Stroke education provided is one of the items which will be tracked by the Neurology Section and reported to/monitored by the NTHCS stroke oversight committee (will need to be formed).

Recommendation 17. We recommended that facility managers provide a stroke education program.

Concur

Target date for completion: September 30, 2015

Facility response: The stroke workgroup will work with education service and nursing education to create a stroke education program. The emergency department, ICU and acute inpatient care unit providers and nursing staff will receive initial acute ischemic stroke training and ongoing education and training. Ongoing education will consist of bi-annual updates that will be coordinated with the help of the stroke director. Inpatient unit physician, speech therapist, physical therapist, and nurse annual training and education will include care of patients with cerebrovascular disease.

Recommendation 18. We recommended that the facility collect and report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: September 30, 2015

Facility response: The facility will create a quality assurance program for acute ischemic stroke. The data will be collected monthly (likely by entering into the IPEC

tool) and reviewed quarterly by the Stroke Center Oversight Committee to monitor these metrics and patient care.

Recommendation 19. We recommended that facility managers ensure that applicable Nursing Service employees have 12-lead electrocardiogram competency assessment and validation included in their competency checklists and 12-lead electrocardiogram competency assessment and validation completed and documented.

Concur

Target date for completion: June 30, 2015

Facility response: 12-lead EKG competency assessment and validation will be completed for all applicable Nursing Service employees no later than June 30, 2015.

Recommendation 20. We recommended that facility managers ensure post-anesthesia care competency assessment and validation is completed for employees on the intensive care unit.

Concur

Target date for completion: June 30, 2015

Facility response: Post anesthesia care competency assessment and validation will be completed for critical care nurses no later than June 30, 2015.

Recommendation 21. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of scopes of practice and includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: Anesthesia will develop and implement an EAM competency assessment and validation program in accordance with VHA Directive 2012-032. Competencies will be documented in accordance with facility policy.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

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, VA Master Specifications.

[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] 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.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] 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.