Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00074-207

Combined Assessment Program Review of the Veterans Health Care System of the Ozarks Fayetteville, Arkansas

April 22, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Veterans Health Care System of the Ozarks
FY	fiscal year
ICU	intensive care unit
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

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of February 9, 2015.

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

- Coordination of Care
- Surgical Complexity

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure licensed independent practitioners' folders do not contain non-allowed information. Require that the Intensive Care Unit Committee documents the review of each code episode and that code reviews include screening for clinical issues prior to the code. Ensure that the Chief of Staff attends Surgical Work Group meetings and that the group documents its review of National Surgical Office reports. Require the Facility Director to approve and sign the written requests for extensions for final peer reviews.

Environment of Care: Require that Environment of Care Committee meeting minutes consistently include discussion regarding community based outpatient clinic rounds deficiencies. Ensure Infection Control Committee meeting minutes consistently include implementation of actions to address all high-risk areas, follow-up on implemented actions, and analysis of surveillance activities and data. Require that patient care areas are in good repair. Correctly tag critical medical equipment on the intensive care unit, and inspect and maintain it. Remove inoperable medical equipment from use.

Medication Management: Annually review the look-alike and sound-alike medication list.

Magnetic Resonance Imaging Safety: Conduct a contrast reaction emergency drill in magnetic resonance imaging. Ensure Level 2 magnetic resonance imaging personnel document resolution of all identified contraindications prior to the scan.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Post stroke guidelines on all required units. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Ensure employees involved in assessing and treating stroke patients receive the required training.

Emergency Airway Management: Revise the emergency airway management policy to include a plan for managing a difficult airway. Ensure a clinician with emergency airway

management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care. Develop and grant a scope of practice that includes emergency airway management for respiratory therapists who have established competency to perform the procedure.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–34, for the full text of the Directors' comments.) We consider recommendations 10, 11, and 19 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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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
- Acute Ischemic Stroke 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 February 9, 2015, 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 Veterans Health Care System of the Ozarks, Fayetteville, Arkansas,* Report No. 12-02190-281, September 18, 2012).

During this review, we presented crime awareness briefings for 155 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 361 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.

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, 10 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
X	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.	• All 10 licensed independent practitioners' folders contained non-allowed information.	**1.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	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 ICU Committee meeting minutes reviewed: • The committee did not document the review of each episode. • Code reviews did not include screening for clinical issues prior to code that may have contributed to the occurrence of the code.	**2.** We recommended that the Intensive Care Unit Committee document the review of each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

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.	Twelve months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff did not attend any meetings. • The group did not document its review of National Surgical Office reports.	**3.** We recommended that the Chief of Staff attend Surgical Work Group meetings and that the Surgical Work Group document its review of National Surgical Office reports.
NA	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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and irretrievability 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.		
X	The facility met any additional elements required by VHA or local policy.	VHA requires that when final peer reviews cannot be completed within 120 days from the determination that a peer review is necessary, the Facility Director needs to document approval of requests for extensions. • In FY 2014, the Facility Director did not approve three of seven written requests for extensions.	**4.** We recommended that the Facility Director approve and sign written requests for extensions for final peer reviews.

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.[b]

We inspected two medical/surgical and the MH inpatient, palliative care, intensive care, post-anesthesia care, and step-down units; the Emergency Department; a primary care clinic; and the spinal cord injury, women's health, and dental outpatient clinics. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 10 critical care 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
X	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.	Eight months of EOC Committee meeting minutes reviewed: • Minutes did not consistently include discussion regarding community based outpatient clinic rounds deficiencies.	**5.** We recommended that Environment of Care Committee meeting minutes consistently include discussion regarding community based outpatient clinic rounds deficiencies.
	The facility conducted an infection prevention risk assessment.		
X	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.	Eight months of Infection Control Committee meeting minutes reviewed: • Minutes did not consistently reflect implementation of actions to address all high-risk areas. • Minutes did not consistently reflect follow-up on actions implemented to address identified problems. • Minutes did not consistently reflect analysis of surveillance activities and data.	**6.** We recommended that the Infection Control Committee meeting minutes consistently include implementation of actions to address all high-risk areas, follow-up on implemented actions, and analysis of surveillance activities and data.
	The facility had established a process for cleaning equipment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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.	• Three of ten patient care areas had chipped doors and doorframes, hallways in need of painting, and baseboards in need of repair. • The two medical/surgical units had inpatient rooms in need of painting.	**7.** We recommended that facility managers ensure patient care areas are in good repair and monitor compliance.
	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 ICU had chipped doors and doorframes.	See recommendation 7.
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
X	The facility met medical equipment requirements in critical care.	• Two critical medical equipment items on the ICU did not have the correct inventory tags; therefore, they were not inspected and maintained as recommended by the manufacturer. • One piece of critical medical equipment on the ICU had a designation of inoperable but was on the unit for patient use.	**8.** We recommended that the facility correctly tag critical medical equipment on the intensive care unit and inspect and maintain it as recommended by the manufacturer and that facility managers monitor compliance. **9.** We recommended that the facility remove inoperable medical equipment from use.
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for CLC		
NA	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.		
NA	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
NA	The facility met fire safety requirements in the CLC.		
NA	The facility met environmental safety requirements in the CLC.		
NA	The facility met infection prevention requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
NA	The facility met medication safety and security requirements in the CLC.		
NA	The facility met medical equipment requirements in the CLC.		
NA	The facility met privacy requirements in the CLC.		
NA	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 18 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected medical/surgical, intensive care, and post-anesthesia care units and the Emergency Department 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
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 annually review the look-alike and sound-alike medication list.	**10.** We recommended that the facility annually review the look-alike and sound-alike medication list.
	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.		
	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.		
	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 36 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 35 employees (30 randomly selected Level 1 ancillary staff and five 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 a physical inspection of the MRI area. 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 a contrast reaction emergency drill in the MRI area.	**11.** We recommended that the facility conduct a contrast reaction emergency drill in magnetic resonance imaging and that facility managers monitor compliance.
	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.	• Three of 10 applicable EHRs did not contain documentation that Level 2 MRI personnel addressed all identified contraindications prior to MRI.	**12.** We recommended that 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.
	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
	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.		

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 29 patients who experienced stroke symptoms, and 10 employee training records (five Emergency Department and five ICU), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, one ICU, and five 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
	The facility's stroke policy addressed all required items.		
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Clinicians did not document evidence of completion of stroke scales for any of the 22 applicable patients.	**13.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	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 on the ICU or the five inpatient units.	**14.** We recommended that facility managers post stroke guidelines on all required units.
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For 13 of the 28 applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**15.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
X	Clinicians provided printed stroke education to patients upon discharge.	• For 16 of the 19 applicable patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**16.** We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility provided training to employees involved in assessing and treating stroke patients.	• Three employees had not completed the web-based training required by the facility.	**17.** We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.
	The facility collected and reported required data related to stroke care.		
	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. 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
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	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.		
	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 nine clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. 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
	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.		
X	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	• Facility policy did not address a plan for managing a difficult airway.	**18.** We recommended that the facility revise the emergency airway management policy to include 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		

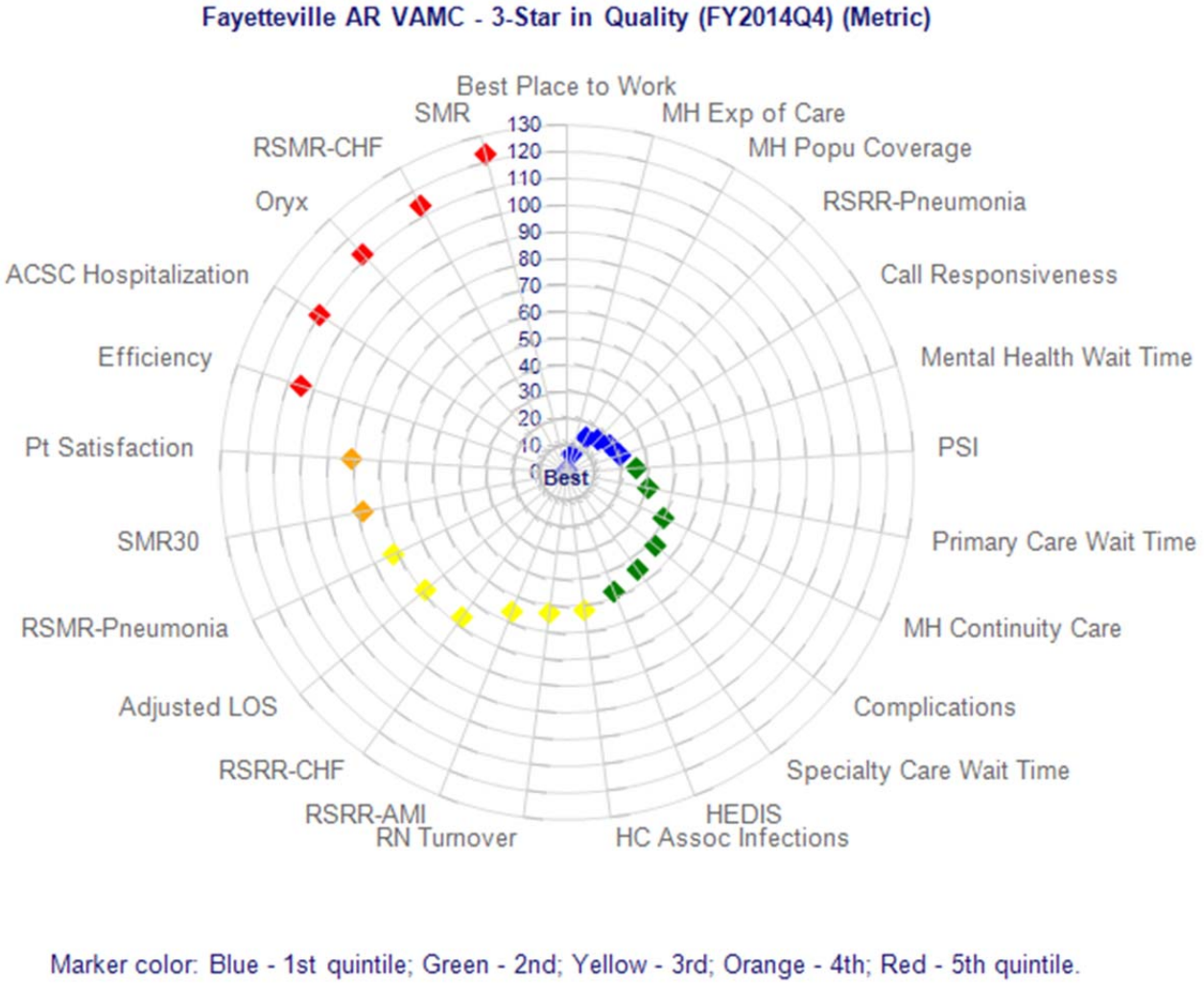
NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful 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		
X	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.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**19.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	Facility and VHA policy reviewed, which require non-providers to have a scope of practice that is approved through the Credentialing and Privileging Committee. • The facility had not developed a scope of practice that included EAM for six respiratory therapists who had established competency for EAM.	**20.** We recommended that the facility develop and grant a scope of practice that includes emergency airway management for respiratory therapists who have established competency to perform the procedure.

Facility Profile (Fayetteville/564) FY 2015 through January 2015[1]	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$237.2
Number (as of February 14, 2015) of:	
• **Unique Patients**	41,437
• **Outpatient Visits**	205,175
• **Unique Employees**[2]	1,280
Type and Number of Operating Beds:	
• **Hospital**	73
• **CLC**	NA
• **MH**	NA
Average Daily Census:	
• **Hospital**	46
• **CLC**	NA
• **MH**	NA
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Gene Taylor (Mt. Vernon)/564BY Harrison/564GA Fort Smith/564GB Branson/564GC Ozark/564GD Jay/564GE
VISN Number	16

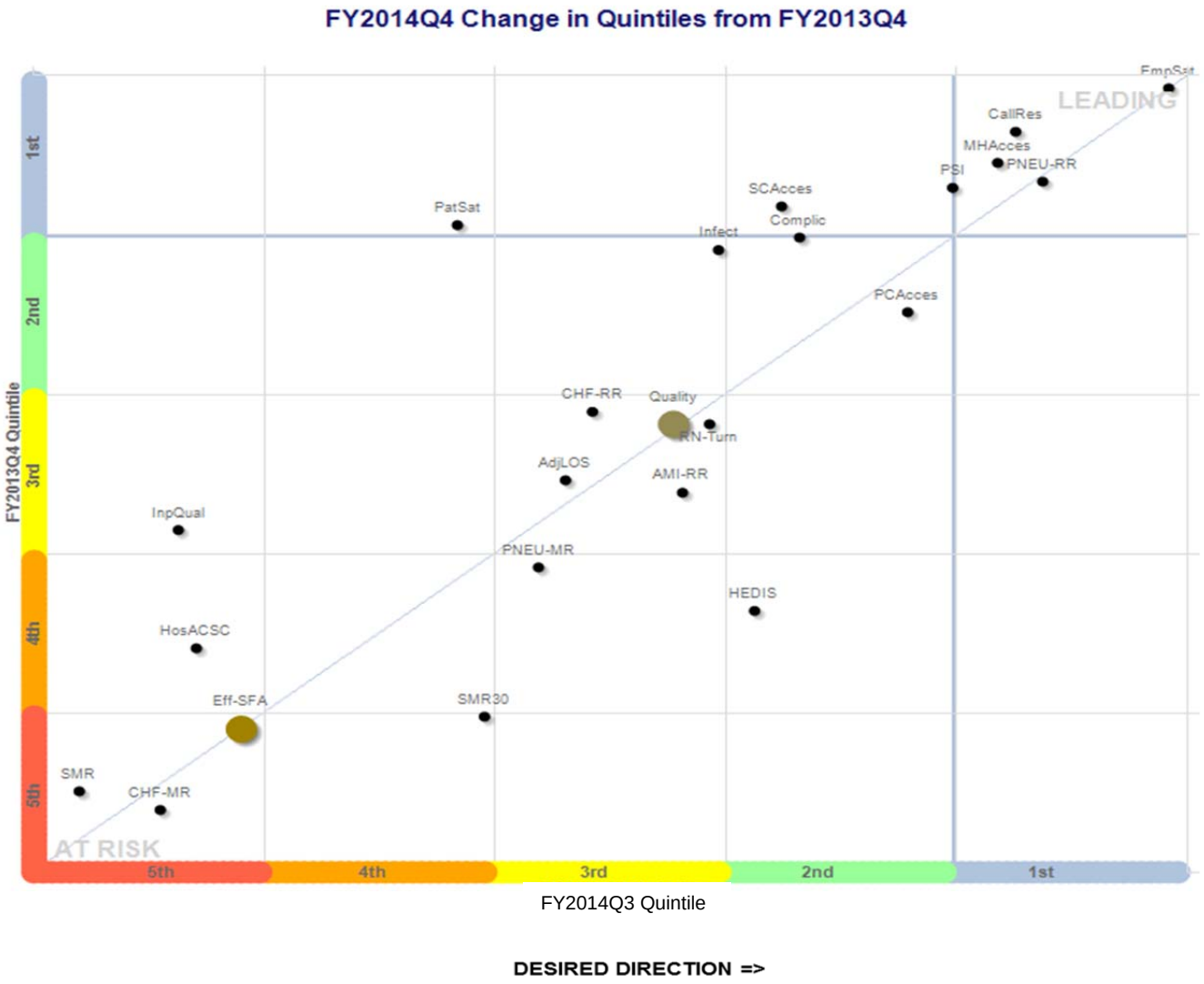
[1] All data is for FY 2015 through January 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

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 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
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 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
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

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 31, 2015

From: Interim Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Veterans Health Care System of the Ozarks, Fayetteville, AR**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concur with the findings, recommendations and corrective actions included in the draft report submitted by the Veterans Health Care System of the Ozarks, Fayetteville, AR.

2. If you have any questions regarding the information submitted, please contact Reba T. Moore, VISN16 Accreditation Specialist at 601-206-7022.

Fernando O. Rivera, FACHE
Interim Network Director, VISN 16

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 31, 2015

From: Director, Veterans Health Care System of the Ozarks (564/00)

Subject: **CAP Review of the Veterans Health Care System of the Ozarks, Fayetteville, AR**

To: Director, South Central VA Health Care Network (10N16)

1. Attached is the Veterans Health Care System of the Ozarks response to the March CAP Review Draft Report.

2. For further concerns or questions please contact Loretta J. Allen, Chief, Quality, Safety and Value. Phone 479-587-5858.

Mark A. Enderle, MD

Director, Veterans Health Care System of the Ozarks (564/00)

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 licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: July 1, 2015

Facility response: The two part folders contain only the information mandated by VA Central Office. The facility discretionary information (BLS, ACLS) was removed during the review. Ten LIP folders will be monitored for three consecutive months for 90% compliance.

Recommendation 2. We recommended that the Intensive Care Unit Committee document the review of each code episode and that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: July 30, 2015

Facility response: Quality, Safety and Value Specialist will review each code episode and include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Each code episode will be documented in the ICU committee minutes and audited for compliance for three consecutive months. This will be reported to Leadership monthly through the Quality, Safety and Value Committee.

Recommendation 3. We recommended that the Chief of Staff attend Surgical Work Group meetings and that the Surgical Work Group document its review of National Surgical Office reports.

Concur

Target date for completion: July 30, 2015

Facility response: The VASQIP Specialist will provide the National Surgical Office reports quarterly to the Surgical Workgroup for inclusion in the minutes. Attendance of the Chief of Staff at the Surgical Work group will be monitored for three consecutive months for 100% compliance. This will be reported to Leadership through the Quality, Safety, and Value Committee.

Recommendation 4. We recommended that the Facility Director approve and sign written requests for extensions for final peer reviews.

Concur

Target date for completion: July 30, 2015

Facility response: 100% of written requests for extensions will be audited for signature by the Director from November 2014 through July 1, 2015. Results will be reported to Leadership monthly through the Quality, Safety, and Value Committee.

Recommendation 5. We recommended that Environment of Care Committee meeting minutes consistently include discussion regarding community based outpatient clinic rounds deficiencies.

Concur

Target date for completion: July 31, 2015

Facility response: EOCC minutes will be updated to include CBOC rounds deficiencies as a discrete item. A compliance benchmark of 90% or greater is expected for three consecutive months. Findings will be reported to Leadership through the Quality, Safety, and Value Committee.

Recommendation 6. We recommended that the Infection Control Committee meeting minutes consistently include implementation of actions to address all high-risk areas, follow-up on implemented actions, and analysis of surveillance activities and data.

Concur

Target date for completion: July 30, 2015

Facility response: Infection Control Committee minutes will be revised to include implementation of actions to address all high risk areas, with follow up on actions, analysis of surveillance activities and data. Three consecutive months of Infection Control minutes will be audited for compliance. Results will be reported to Leadership through the Quality, Safety and Value Committee monthly.

Recommendation 7. We recommended that facility managers ensure patient care areas are in good repair and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Engineering service will create a preventive maintenance entries in AMES/MERS to trigger and track refresh of finishes (painting of door frames, touchup painting of patient rooms, hallways, clean utility rooms, etc…) in the inpatient care

areas. This will not supplant response to EOC hazardous surveillance rounds work orders for like issues but will augment that process. The preventive maintenance will ensure that these areas receive updated appearances on an annual, recurring basis. Preventive maintenance entries will be segmented to cover all inpatient care areas and to allow for balancing of the workload throughout the year. This will be reported monthly to Leadership through the EOCC.

Recommendation 8. We recommended that the facility correctly tag critical medical equipment on the intensive care unit and inspect and maintain it as recommended by the manufacturer and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2015

Facility response: Biomedical Engineering will create an SOP to ensure better execution and documentation of tag verification as part of the inspection/preventive maintenance process. The Chief of the Biomedical Engineering department will perform monthly inspections of the biomedical equipment in the intensive care unit using a tracer approach on a minimum of five pieces of equipment to evaluate the accuracy and effectiveness of the preventive maintenance system. The results of these tracer based inspections will be reported to the EOCC.

Recommendation 9. We recommended that the facility remove inoperable medical equipment from use.

Concur

Target date for completion: August 31, 2015

Facility response: Biomedical Engineering and Logistics will create an SOP to provide better guidance to the medical center on the equipment turn-in process. A training initiative will ensure the education of equipment users throughout the medical center. The Chief of Logistics will provide a monthly report of equipment turn-ins to the Chief of Biomedical Engineering. The Chief of Biomedical Engineering will audit the report to verify that the equipment has been removed from the medical equipment inventory and that the equipment is physically removed from service. The results of these audits will be reported to the EOCC.

Recommendation 10. We recommended that the facility annually review the look-alike and sound-alike medication list.

Concur

Target date for completion: January 26, 2015

Facility response: The Annual review of the look-alike and sound-alike medication list was completed by the Pharmacy and Therapeutics committee. This will be added

annually to the Pharmacy and Therapeutics Committee for review. VHSO would like to request closure of this recommendation.

Recommendation 11. We recommended that the facility conduct a contrast reaction emergency drill in magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: January 14, 2015

Facility response: VHSO completed the contrast reaction emergency drill in MRI on 1-14-2015. This drill will be performed annually and recorded in the Radiology Quality Improvement/Quality Control Committee. VHSO would like to request closure of this recommendation.

Recommendation 12. We recommended that 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: July 30, 2015

Facility response: All cases with identified MRI contraindications will be audited for documentation of resolution prior to MRI being performed for three consecutive months at 90% compliance. Results will be reported to Leadership monthly through the Quality, Safety and Value Committee.

Recommendation 13. 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: July 30, 2015

Facility response: The Acute Ischemic Stroke Committee will develop a mechanism to include the NIH scale in CPRS. After implementation 100% of AIS patients will be monitored for three consecutive months for 90% compliance. This will be reported to Leadership monthly in the Quality, Safety and Value Committee.

Recommendation 14. We recommended that facility managers post stroke guidelines on all required units.

Concur

Target date for completion: July 30, 2015

Facility response: The Acute Ischemic Stroke Committee will develop and distribute stroke guidelines to nursing managers on all required units. Quality Management staff will perform monthly tracers to validate placement of guidelines on all required units for three consecutive months. This will be reported to Leadership monthly in the Quality, Safety and Value Committee.

Recommendation 15. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: July 30, 2015

Facility response: A dysphagia screen will be developed and added to the Emergency Department triage note with a reminder to perform the dysphagia screen. All AIS patients will be monitored for dysphagia screening by Quality and Performance Specialist for three consecutive months for 90% compliance. This will be reported monthly to Leadership in the Quality, Safety and Value Committee.

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: July 30, 2015

Facility response: The Nursing Discharge summary will have stroke education built in to allow it to be printed off and provided to AIS patients. All AIS patient records will be monitored for three consecutive months for 90% compliance. This will be reported to Leadership monthly through the Quality, Safety and Value Committee.

Recommendation 17. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2015

Facility response: All clinical staff on station as of February 13, 2015 will have training completed by May 31, 2015.

Recommendation 18. We recommended that the facility revise the emergency airway management policy to include a plan for managing a difficult airway.

Concur

Target date for completion: July 30, 2015

Facility response: The MCM for Emergency Airway management will be updated to include a plan for the management of difficult airways. This MCM will be reviewed by Leadership for concurrence in the Quality, Safety and Value Committee when completed.

Recommendation 19. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: February 10, 2015

Facility response: Although trained and competent staff were available during all hours that the facility provides patient care, the respiratory therapists who were included in the staff that provided the service had functional statements and not scopes of practice. While the OIG were on site on February 10, 2015, scopes of practice were developed for each of the respiratory therapists and approved through the Physicians Professional Standards Board, the Executive Committee for the Medical staff, and the Medical Center Director. VHSO requests closure of this recommendation.

Recommendation 20. We recommended that the facility develop and grant a scope of practice that includes emergency airway management for respiratory therapists who have established competency to perform the procedure.

Concur

Target date for completion: March 31, 2015

Facility response: Scopes of practice were developed for each of the respiratory therapists and approved through the Physicians Professional Standards Board, The Executive Committee for the Medical Staff and the Medical Center Director. Respiratory therapists who are hired will complete the training, demonstrate competency, and have an approved scope of practice prior to providing Emergency Airway management coverage. A 100% review of respiratory therapists who perform out-of-OR airway management (OOORAM) service folders will be conducted to verify all have an appropriate scope of practice that includes out-of-OR airway management. This will be reported to Leadership through the Quality, Safety and Value Committee.

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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U.S. House of Representatives: Billy Long, Markwayne Mullin, Bruce Westerman, Steve Womack

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.

[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.