Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00076-350

Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System Omaha, Nebraska

May 15, 2015

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Nebraska-Western Iowa 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
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration

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Executive Summary

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

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

- Environment of Care
- Coordination of Care
- Surgical Complexity
- Mental Health Residential Rehabilitation Treatment Program

Recommendations: We made recommendations in the following five activities:

Quality Management: Ensure the Accident Review Board gathers, tracks, and shares patient handling injury data. Include most services and program areas in the review of electronic health record quality.

Medication Management: Institute unique refrigerator bin storage practices for look-alike and sound-alike medications in all areas.

Magnetic Resonance Imaging Safety: Ensure 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.

Acute Ischemic Stroke Care: Complete and document National Institutes of Health stroke scales for each stroke patient. Provide printed stroke education to patients upon discharge. Ensure that employees involved in assessing and treating stroke patients receive the training required by the facility.

Emergency Airway Management: Ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data, all required subject matter content elements, completion of a written test, and one of the three required components.

Comments

The Acting 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 27–33, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objective and Scope

Objective

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- MH RRTP

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

The review covered facility operations for FY 2014 and FY 2015 through March 12, 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 VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska, Report No. 12-00886-204, June 22, 2012).

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 508 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
	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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	Four months of Accident Review Board meeting minutes reviewed: • The board did not gather, track, and share patient handling injury data.	**1.** We recommended that the Accident Review Board gather, track, and share patient handling injury data.
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • The review of EHR quality did not include EHRs from most services and program areas.	**2.** We recommended that the facility include most services and program areas in the review of electronic health record quality.
	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 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]

At the Omaha campus, we inspected the psychiatric intensive care, three medical/surgical, and the critical care units; three primary care outpatient clinics; the Emergency Department; and the physical and occupational therapy area. At the Grand Island campus, we inspected the CLC. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 29 employee training records (nine critical care and 20 CLC) and 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 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected an inpatient medical/surgical unit, the post-anesthesia care unit, a critical care unit, 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.		
NA	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.	• In three of the four areas inspected, the facility did not institute unique refrigerator bin storage practices for look-alike and sound-alike medications.	**3.** We recommended that the facility institute unique refrigerator bin storage practices for look-alike and sound-alike medications in all areas and that facility managers monitor compliance.
	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 47 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors properly titled the requests. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

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

We reviewed relevant documents and the training records of 43 employees (30 randomly selected Level 1 ancillary staff and 13 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 one MRI area. 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 completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.		
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Ten of the applicable14 EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**4.** 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.
	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.		
NA	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 34 patients who experienced stroke symptoms, and 10 employee training records (five Emergency Department and five critical care unit), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, a critical care unit, and two acute inpatient units (medical/surgical and post-anesthesia care). 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.	• For nine of the 29 applicable patients, clinicians did not document evidence of completion of stroke scales.	**5.** 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.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
X	Clinicians provided printed stroke education to patients upon discharge.	• None of the 25 applicable patients' EHRs contained documentation that clinicians provided stroke education to the patients/caregivers.	**6.** 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.	• Two employees did not have documentation of stroke training.	**7.** 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.		
	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 Veterans Integrated Service Network 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 11 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 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 10 clinicians with reassessments for continued EAM competency had: o Clinician-specific EAM data reviewed o Documentation of all required subject matter content elements and completion of a written test o Evidence of successful airway management and intubation of at least one patient in the preceding 2 years, written certification of airway management competency from the evaluation superior at the non-VA facility, or successful demonstration of airway management and intubation skills to the facility subject matter expert	**8.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance. **9.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and completion of a written test and that facility managers monitor compliance. **10.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.
	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.		
	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.		

MH RRTP

The purpose of this review was to determine whether the facility's Psychosocial RRTP complied with selected EOC requirements.[i]

We reviewed relevant documents, inspected the Psychosocial RRTP, and conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

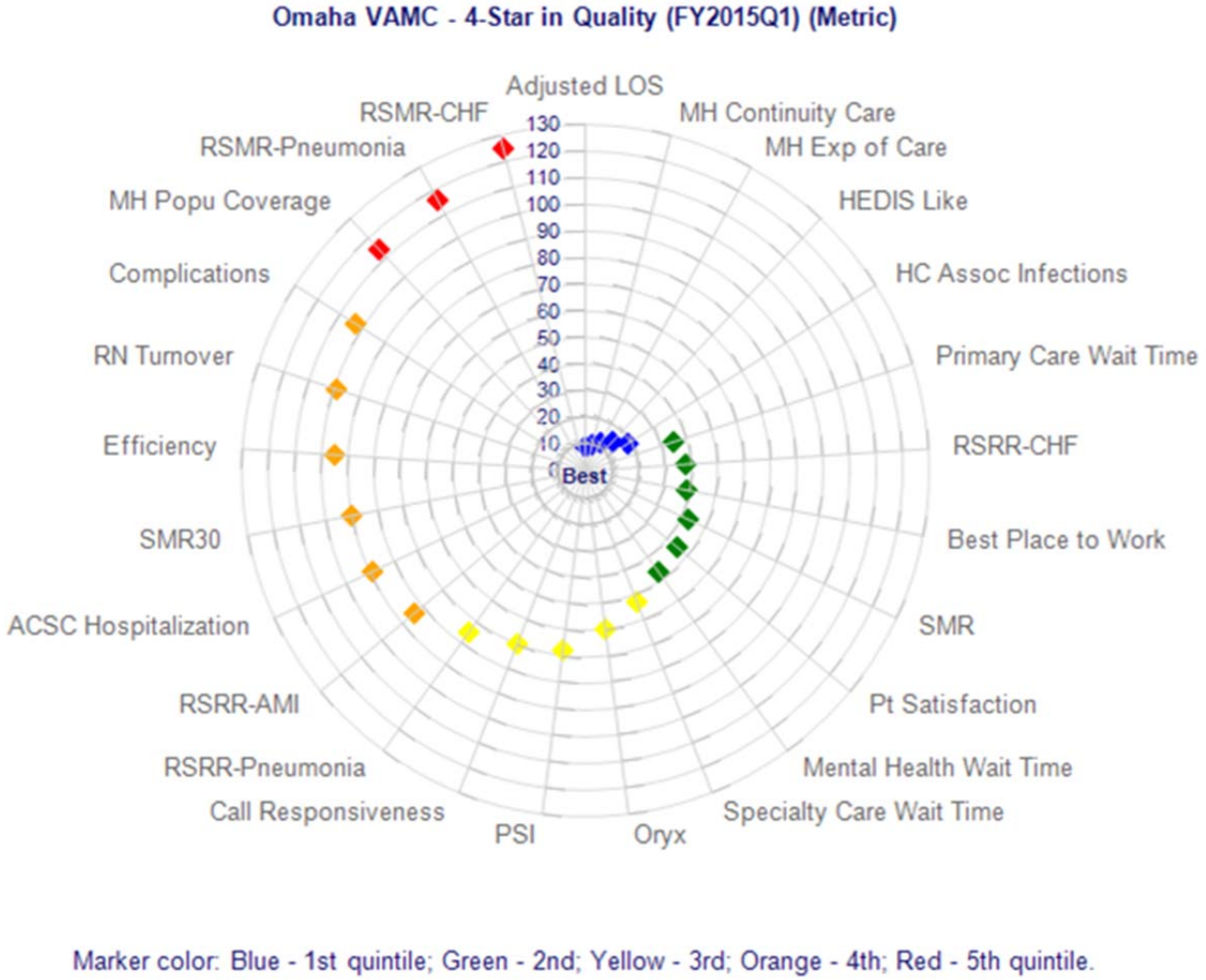
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP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

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

Facility Profile (Omaha/636) FY 2015 through February 2015[1]	
Type of Organization	Secondary
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$866
Number (as of March 17, 2015) of:	
• **Unique Patients**	42,301
• **Outpatient Visits**	257,547
• **Unique Employees**[2]	4,543
Type and Number of Operating Beds:	
• **Hospital**	100
• **CLC**	76
• **MH**	42
Average Daily Census:	
• **Hospital**	56
• **CLC**	36
• **MH**	31
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Grand Island/636A4 Lincoln/636A5 Norfolk/636GA North Platte/636GB Bellevue/636GL Shenandoah/636GP Holdrege/636GQ
Veterans Integrated Service Network Number	23

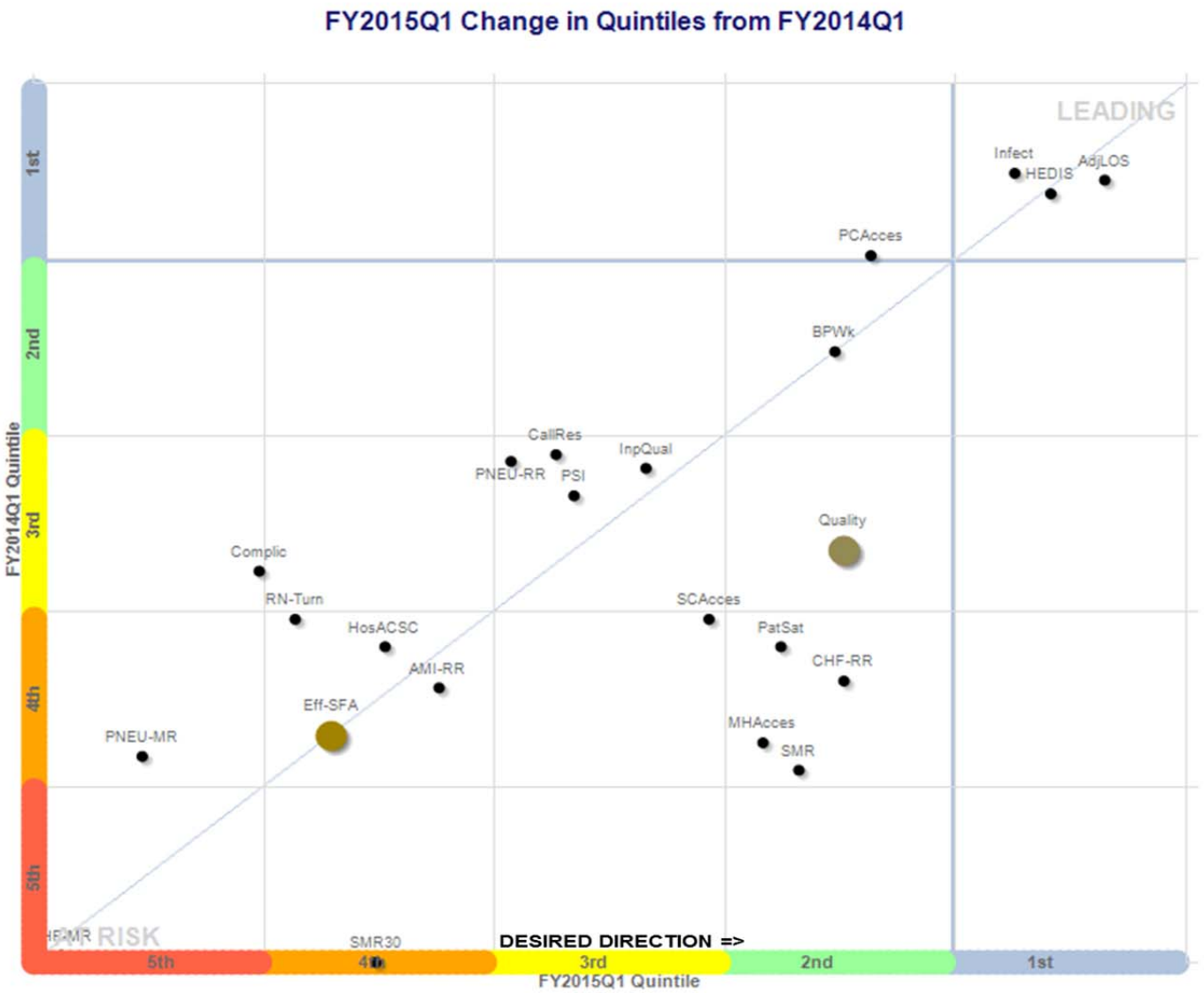
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



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

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: April 20, 2015

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

Subject: **CAP Review of the VA Nebraska-Western Iowa Health Care System, Omaha, NE**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

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

2. If you have any questions or require additional information, please contact Linda Muell, Manager, Quality Management at (402) 995-4758.

Steven C. Julius, M.D.

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 17, 2015

From: Director, VA Nebraska-Western Iowa Health Care System (636/00)

Subject: **CAP Review of the VA Nebraska-Western Iowa Health Care System, Omaha, NE**

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

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

2. If you have any questions or require additional information, please contact Linda Muell, Manager, Quality Management at (402) 995-4758.

Original signed by

B. DON BURMAN, MHA
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Accident Review Board gather, track, and share patient handling injury data.

Concur

Target date for completion: July 2015

Facility response:

- The Safe Patient Handling and Movement Facility Champion/Coordinator (SPHM FC/C) will report findings related to patient handling and mobility injuries identified as Lifting and Repositioning Injuries in the ASISTs database quarterly to the Accident Review Board (ARB).
  – Started this January, 2015
- The ARB will report quarterly the patient handling and mobility trends and concerns to the Environment of Care Council (EOC). The EOC will address all negative trends and concerns with the SPHM FC/C and affected stakeholders in order to rectify.
  – Started this January, 2015
- The SPHM FC/C will report annually to the Executive Leadership Board.

Recommendation 2. We recommended that the facility include most services and program areas in the review of electronic health record quality.

Concur

Target date for completion: September 2015

Facility response:
The Medical Record Review Subgroup of Medical Record Committee will:

- Conduct an inventory of service lines/programs that are and are not submitting data on their Electronic Health Record (EHR) quality.
  – This will be completed by May 30, 2015.
- Make the determination of what service lines/programs will report to the Medical Record Committee.
  – This will be completed by July 31, 2015.
- Develop a quarterly reporting schedule; notify and educate the service lines/programs.

  - Education to include:
    - what data will be submitted
    - how the data will be submitted
    - what frequency the data will be reported to the Medical Record Committee
    - how the data will be used for improvement and action

Recommendation 3. We recommended that the facility institute unique refrigerator bin storage practices for look-alike and sound-alike medications in all areas and that facility managers monitor compliance

Concur

Target date for completion: September 2015

Facility response:

- The Pharmacy management team will measure, procure, and organize bins/totes for the inpatient medication refrigerators for the separation of Look Alike/Sound Alike medications to inpatient areas per the requirement.
- Implementation for these bins are based on purchasing requirements – plan for installation by June 30, 2015.
- The inpatient pharmacy manager will require monthly ward inspections from pharmacy technician staff of these areas and provide documentation that these areas are compliant with this organization requirement starting July 2015.
- Compliance/Non-compliance with these areas will be reported to pharmacy manager and nurse manager of that area. Follow up to issues and concerns will be addressed immediately and at nurse/pharmacy meetings.

Recommendation 4. 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: September 2015

Facility response:

- Radiology Supervisor made changes to the radiology policy RAD-131 on 1-27-15.
- The radiology technicians will use the magnetic resonance imaging (MRI) screening form and validate if contraindications are safe, documenting references as needed.
  - These actions have been completed
- To verify compliance the lead MRI technologist will perform an EHR review of 25 patients quarterly with a goal of 90% compliance for 3 quarters.
  - To begin May 1, 2015

- Results of the audit will be address at the Radiology Safety Committee. Action will be taken as appropriate for noncompliance.

Recommendation 5. 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 2015

Facility response:

- The Acute Stroke Coordinators (ER and Hospitalist) in conjunction with the Chief of Neurology developed a Stroke Note and revised the Acute Stroke SBAR. Both items include the National Institute of Health Stroke scales. The Provider fills out a Stroke Note and an Acute Stroke SBAR with each Acute Stroke patient seen in this facility.
  – These actions have been completed.
- Compliance will be monitored by doing random sampling of medical records quarterly beginning June 1, 2015 and discussed in the Acute Stroke Case workgroup, with appropriate follow up completed.

Recommendation 6. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response:

- The Acute Stroke Coordinators (ER and Hospitalist) in conjunction with the Chief of Neurology developed a mandatory Computerized Patient Record System (CPRS) checkbox for Stroke Education at discharge in the Nurse Discharge note.
  – These actions have been completed.
- Compliance will be monitored by doing random sampling of medical records quarterly beginning June 1, 2015 with a target of 90% compliance for 3 consecutive months with results discussed in the Acute Stroke Case workgroup.

Recommendation 7. 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 2015

Facility response:

- The Acute Stroke Coordinators (ER and Hospitalist) in conjunction with the Chief of Neurology will arrange for pertinent providers to do an Acute Stroke Talent Management System (TMS) training module.
- This module will be mandated for yearly review.
- This will be monitored through the Chief of Medicine with results reported to the Medical Executive Committee (MEC) on a quarterly basis.

Recommendation 8. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes reviews of clinician-specific emergency airway management data and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response:

- Out of OR Airway Management (OOORAM), workgroup developed and implemented all components of the OOORAM directive and are compliant with the OOORAM policy as of 1/2015.
- All intubations are monitored with quarterly reports routed to MEC beginning June 1, 2015.
- Each provider is tracked and reviewed for compliance with facility policy.

Recommendation 9. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes all required subject matter content elements and completion of a written test and that facility managers monitor compliance.

Concur

Target date for completion: Completed

Facility response:

- Policy revisions have been made with all three components, Talent Management System (TMS), Simulation lab, and Operating Room intubations required every 2 years.
  - Completed
- Results are monitored by the Pulmonology and Credentialing department quarterly with compliance rates reported to MEC.

Recommendation 10. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes one of the three required components and that facility managers monitor compliance.

Concur

Target date for completion: September 2015

Facility response:

- Leaders ensure that clinician reassessment for continued emergency airway management competency includes completion of all three required components.
- Facility managers monitor compliance via TMS, Simulation lab, and Operating Room intubations every 2 years per NWI policy.
- Compliance intubation data and Out of OR Airway Management (OOORAM) workgroup reports are presented to the Medicine Invasive Procedure (MIPC) Committee on a quarterly basis for review. The MIPC reports to the Executive Committee.

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Endnotes

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

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

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

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

[f] 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.

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