



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-00617-539**

**Combined Assessment Program  
Review of the  
William S. Middleton  
Memorial Veterans Hospital  
Madison, Wisconsin**

**September 30, 2015**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

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## Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	William S. Middleton Memorial Veterans Hospital
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
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, and to provide crime awareness briefings. We conducted the review the week of August 3, 2015.

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

- Quality Management
- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring
- Advance Directives
- Surgical Complexity
- Emergency Airway Management
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishment was achieving American Nurses Credentialing Center Magnet recognition.

**Recommendation:** We made a recommendation in the following activity:

*Environment of Care:* Ensure designated employees receive evacuation device training.

### Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review finding and recommendation and provided an acceptable improvement plan. (See Appendixes C and D, pages 26–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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

## Objectives and Scope

### Objectives

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

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

### Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- 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 August 6, 2015, and inspectors conducted the review 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 William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin*, Report No. 13-00431-173, April 12, 2013).

During this review, we presented crime awareness briefings for 70 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. We distributed an electronic survey to all facility employees and received 563 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

## Reported Accomplishment

### **American Nurses Credentialing Center Recognition**

In October 2014, the facility achieved Magnet recognition from the American Nurses Credentialing Center's Commission on Magnet. The American Nurses Credentialing Center Magnet Recognition Program® recognizes health care organizations that demonstrate excellence in nursing services. Magnet recognition is the highest national credential for nursing excellence, serving as the gold standard for nursing practice.

## Results and Recommendations

### QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.<sup>a</sup>

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. 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
	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. <ul style="list-style-type: none"> <li>• The committee routinely reviewed aggregated data.</li> <li>• QM, patient safety, and systems redesign appeared to be integrated.</li> </ul>		
	Peer reviewed deaths met selected requirements: <ul style="list-style-type: none"> <li>• Peers completed reviews within specified timeframes.</li> <li>• The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings.</li> <li>• Involved providers were invited to provide input prior to the final Peer Review Committee determination.</li> </ul>		



NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>Credentialing and privileging processes met selected requirements:</p> <ul style="list-style-type: none"> <li>• Facility managers reviewed privilege forms annually and ensured proper approval of revised forms.</li> <li>• Facility managers ensured appropriate privileges for licensed independent practitioners.</li> <li>• Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation.</li> <li>• Facility managers properly maintained licensed independent practitioners' folders.</li> </ul>		
	<p>Observation bed use met selected requirements:</p> <ul style="list-style-type: none"> <li>• The facility gathered data regarding appropriateness of observation bed usage.</li> <li>• The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.</li> </ul>		
	<p>The process to review resuscitation events met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee reviewed episodes of care where resuscitation was attempted.</li> <li>• Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code.</li> <li>• The facility collected data that measured performance in responding to events.</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>The surgical review process met selected requirements:</p> <ul style="list-style-type: none"> <li>• An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes.</li> <li>• The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement.</li> <li>• The Surgical Work Group reviewed additional data elements.</li> </ul>		
	<p>Clinicians appropriately reported critical incidents.</p>		
	<p>The safe patient handling program met selected requirements:</p> <ul style="list-style-type: none"> <li>• A committee provided program oversight.</li> <li>• The committee gathered, tracked, and shared patient handling injury data.</li> </ul>		
	<p>The process to review the quality of entries in the EHR met selected requirements:</p> <ul style="list-style-type: none"> <li>• A committee reviewed EHR quality.</li> <li>• A committee analyzed data at least quarterly.</li> <li>• Reviews included data from most services and program areas.</li> </ul>		
	<p>The policy for scanning internal forms into EHRs included the following required items:</p> <ul style="list-style-type: none"> <li>• Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate.</li> <li>• A correction process if scanned items have errors.</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<ul style="list-style-type: none"> <li>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.</li> </ul>		
	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 emergency management.<sup>b</sup>

We inspected the cardiac intensive care, surgical intensive care, medical inpatient, medical/surgical, inpatient and outpatient MH, community living center/rehabilitation, transitional care, and hospice units; the Emergency Department; the dental clinic; and two primary care clinics. We also performed a perimeter inspection of the eighth floor intensive care/cardiac care units' construction site. Additionally, we reviewed relevant documents, including 10 employee training and competency records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	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.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	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.		
	<b>Areas Reviewed for SCI Center</b>		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	<b>Areas Reviewed for Emergency Management</b>		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
X	Employees received training and competency assessment on use of emergency evacuation devices.	<ul style="list-style-type: none"> <li>Eight of 10 designated employees did not have evacuation device training in accordance with the Emergency Operations Plan.</li> </ul>	<ol style="list-style-type: none"> <li>We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.</li> </ol>
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
<b>Areas Reviewed for Construction Safety</b>			
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
	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.<sup>c</sup>

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the Emergency Department, the cardiac intensive care unit, the post-anesthesia care unit, and a medical/surgical unit 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. 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 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
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, 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.		
NA	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.		



<b>NM</b>	<b>Areas Reviewed (continued)</b>	<b>Findings</b>	<b>Recommendations</b>
	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.<sup>d</sup>

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 43 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: <ul style="list-style-type: none"> <li>• Provide training in the use of the computerized consult package</li> <li>• Review and manage consults</li> </ul>		
	Consult requests met selected requirements: <ul style="list-style-type: none"> <li>• Requestors included the reason for the consult.</li> <li>• Requestors selected the proper consult title.</li> <li>• Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.</li> </ul>		
	The facility met any additional elements required by VHA or local policy.		

## CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.<sup>e</sup>

We reviewed relevant documents, including qualifications and dosimetry monitoring for five CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 48 randomly selected patients who had a CT scan January 1–December 31, 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
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: <ul style="list-style-type: none"> <li>• A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance</li> <li>• CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer</li> <li>• A process for managing/reviewing CT protocols and procedures to follow when revising protocols</li> <li>• Radiologist review of appropriateness of CT orders and specification of protocol prior to scans</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
NA	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
NA	The facility complied with any additional elements required by VHA or local policy.		

## ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.<sup>f</sup>

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 46 randomly selected patients who had an acute care admission January 1–December 31, 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
	The facility had an AD policy that addressed: <ul style="list-style-type: none"> <li>• AD notification, screening, and discussions</li> <li>• Proper use of AD note titles</li> </ul>		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. <ul style="list-style-type: none"> <li>• Employees correctly posted patients' AD status.</li> </ul>		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. <ul style="list-style-type: none"> <li>• When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.</li> </ul>		
	The facility met 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.<sup>9</sup>

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. <ul style="list-style-type: none"> <li>• The facility reviewed and implemented recommendations made by the Veterans Integrated Service Network Chief Surgical Consultant.</li> </ul>		
	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.<sup>h</sup>

We reviewed relevant documents, including competency assessment documentation of 12 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. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
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: <ul style="list-style-type: none"> <li>• Competency assessment and reassessment processes</li> <li>• Use of equipment to confirm proper placement of breathing tubes</li> <li>• A plan for managing a difficult airway</li> </ul>		
NA	Initial competency assessment for EAM included: <ul style="list-style-type: none"> <li>• Subject matter content elements and completion of a written test</li> <li>• Successful demonstration of procedural skills on airway simulators or mannequins</li> <li>• Successful demonstration of procedural skills on patients</li> </ul>		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included:</p> <ul style="list-style-type: none"> <li>• Review of clinician-specific EAM data</li> <li>• Subject matter content elements and completion of a written test</li> <li>• Successful demonstration of procedural skills on airway simulators or mannequins</li> <li>• 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</li> <li>• A statement related to EAM if the clinician was not a licensed independent practitioner</li> </ul>		
	<p>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.</p>		
	<p>Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.</p>		
	<p>The facility complied with any additional elements required by VHA or local policy.</p>		



**MH RRTP**

The purpose of this review was to determine whether the facility’s Substance Abuse RRTP complied with selected EOC requirements.<sup>1</sup>

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

NM	Areas Reviewed	Findings	Recommendations
	The 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 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.		

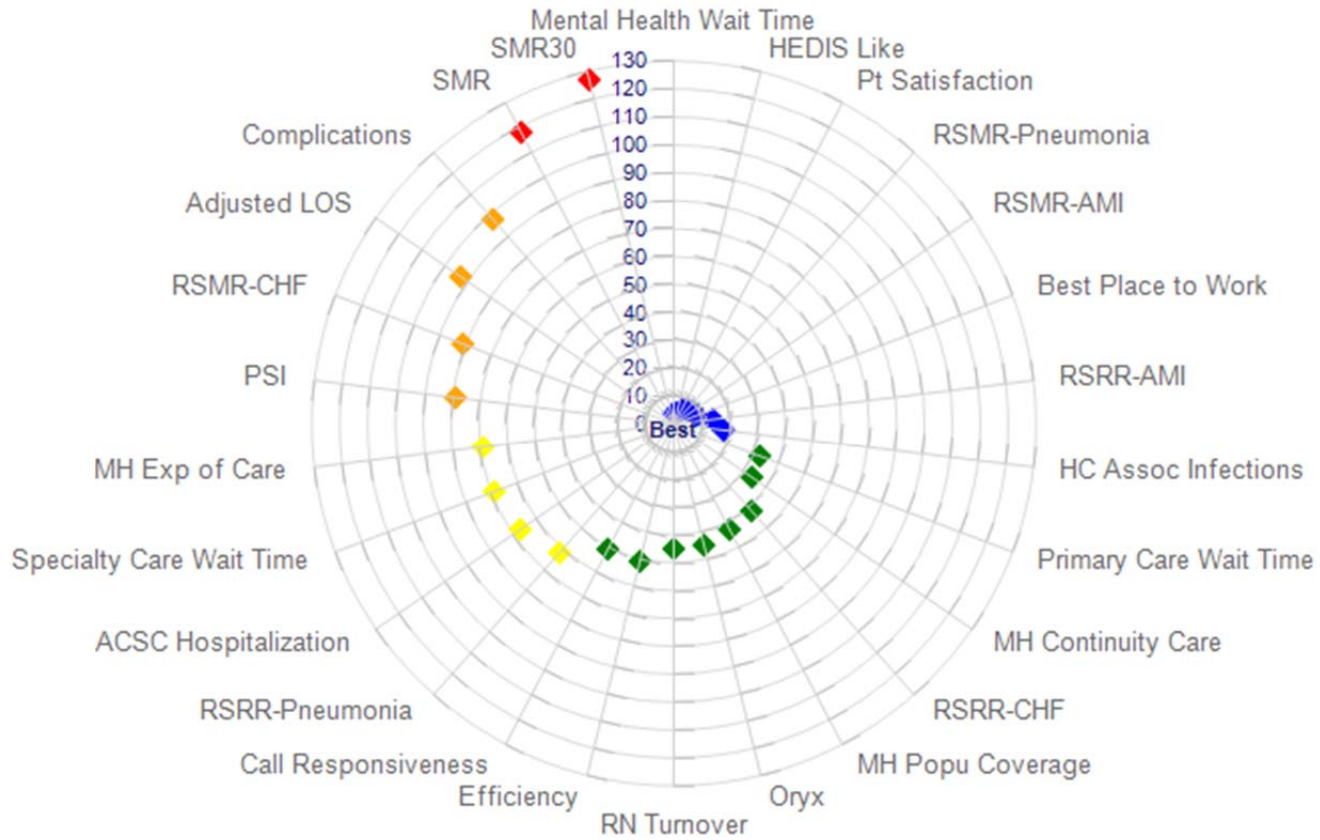
<b>Facility Profile (Madison/607) FY 2015 through July 2015<sup>1</sup></b>	
<b>Type of Organization</b>	Tertiary
<b>Complexity Level</b>	1b-High complexity
<b>Affiliated/Non-Affiliated</b>	Affiliated
<b>Total Medical Care Budget in Millions</b>	\$322.7
<b>Number of:</b>	
• <b>Unique Patients</b>	37,845
• <b>Outpatient Visits</b>	371,518
• <b>Unique Employees<sup>2</sup></b>	1,931
<b>Type and Number of Operating Beds:</b>	
• <b>Hospital</b>	85
• <b>Community Living Center</b>	26
• <b>MH</b>	12
<b>Average Daily Census:</b>	
• <b>Hospital</b>	67
• <b>Community Living Center</b>	20
• <b>MH</b>	10
<b>Number of Community Based Outpatient Clinics</b>	5
<b>Location(s)/Station Number(s)</b>	Janesville/607GC Baraboo/607GD Beaver Dam/607GE Freeport/607GF Rockford/607HA
<b>Veterans Integrated Service Network Number</b>	12

<sup>1</sup> All data is for FY 2015 through July 2015 except where noted.

<sup>2</sup> Unique employees involved in direct medical care (cost center 8200).

### Strategic Analytics for Improvement and Learning (SAIL)<sup>3</sup>

Madison VAMC - 3-Star in Quality (FY2015Q2) (Metric)

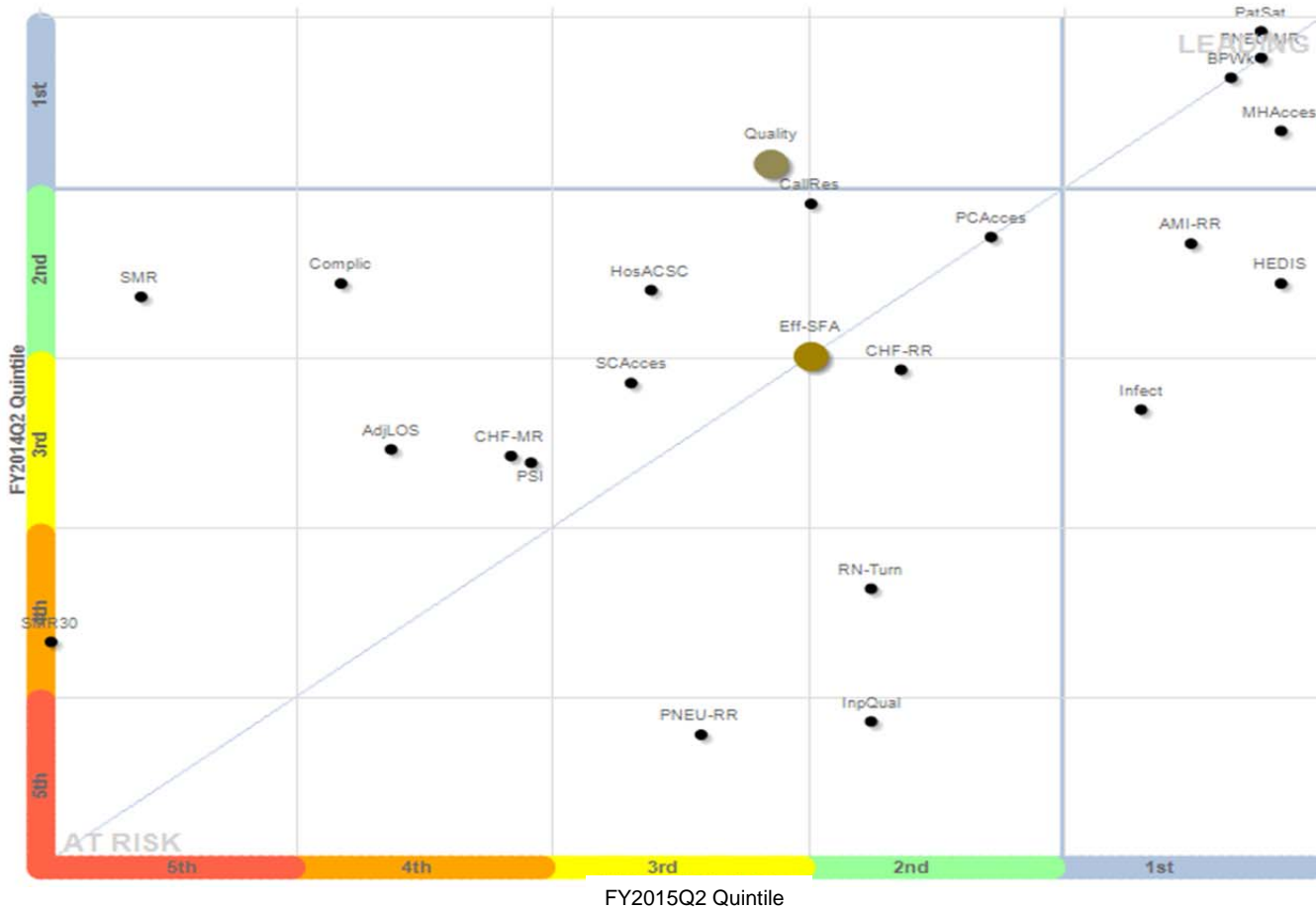


Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

<sup>3</sup> Metric definitions follow the graphs.

## Scatter Chart

FY2015Q2 Change in Quintiles from FY2014Q2



**NOTE**

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

DESIRED DIRECTION ==>

DESIRED DIRECTION ==>

## 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

## Acting Veterans Integrated Service Network Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** September 10, 2015

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

**Subject:** **CAP Review of the William S. Middleton Memorial Veterans Hospital, Madison, WI**

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

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

1. Attached please find the CAP response to the draft report from the William S. Middleton Memorial Veterans Hospital, Madison WI review.
2. I have reviewed the completed response.
3. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at William S. Middleton Memorial Veterans Hospital.



James W. Rice  
Acting Network Director

## Acting Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** September 3, 2015

**From:** Acting Director, William S. Middleton Memorial Veterans Hospital  
(607/00)

**Subject:** **CAP Review of the William S. Middleton Memorial Veterans  
Hospital, Madison, WI**

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

1. Thank you for the opportunity to review the draft report on the CAP review at the William S. Middleton Memorial Veterans Hospital and Clinics, Madison, WI.
2. I have reviewed the document and concur with the recommendation. A corrective action plan has been established with a completion date, as detailed in the attached report.

  
CHRISTINE KLECKNER



## Comments to OIG's Report

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

### **OIG Recommendation**

**Recommendation 1.** We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: The Emergency Operations Plan, Annex M – Facility Evacuation Plan, was updated September 10, 2015, to indicate Environmental Support Services (ESS) Housekeeping Supervisory and Lead staff as the primary designated employees for leading the physical vertical evacuation of non-ambulatory patients, visitors and staff. ESS Housekeeping Supervisory and Lead staff will use evacuations devices such as the Stryker Evacuation Chair, and instruct others on proper use as needed. As of September 1, 2015, 100 percent of ESS Housekeeping Supervisory and Lead Staff received evacuation device training. This training will be conducted during initial orientation for 100 percent of ESS Supervisory and Lead staff and will be documented in their employee training folder. The Emergency Operations Plan also indicates that during real events trained ESS Housekeeping Supervisory or Lead staff will provide evacuation device Just-In-Time training to other staff as necessary. After-action reports will incorporate an opportunity to document the just-in time training when applicable.

## Office of Inspector General Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
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F. James Sensenbrenner

This report is available at [www.va.gov/oig](http://www.va.gov/oig).

## Endnotes

<sup>a</sup> 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.

<sup>b</sup> References used for this topic included:

- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, “Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection,” Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

<sup>c</sup> 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.

<sup>d</sup> The reference used for this topic was:

- Under Secretary for Health, “Consult Business Rule Implementation,” memorandum, May 23, 2013.

<sup>e</sup> References used for this topic included:

- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, “Radiation risks of diagnostic imaging,” Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, “Online Guide,” updated October 4, 2011.
- The American College of Radiology, “ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT,” Revised 2012.

<sup>f</sup> The references used for this topic included:

- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

<sup>g</sup> 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.

<sup>h</sup> 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.

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<sup>i</sup> 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.