Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00622-06

Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas

October 19, 2015

Washington, DC 20420

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

Glossary

AD	advance directive
CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Central Arkansas Veterans Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 17, 2015.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following activity:

- Surgical Complexity

Recommendations: We made recommendations in the following seven activities and follow-up review area:

Quality Management: Ensure the Cardiopulmonary Resuscitation Subcommittee reviews each code episode. Require that the Operating Room Management Council meets monthly, includes the Chief of Staff and Surgical Quality Nurse as members, and documents its review of National Surgical Office reports. Review all surgical deaths with identified problems or opportunities for improvement.

Environment of Care: Require that the Infection Prevention and Control Sub-Committee documents follow-up on actions implemented to address identified problems. Ensure patient care areas are clean. Repair damaged furniture in patient care areas, or remove it from service. Ensure designated employees receive evacuation device training.

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

Coordination of Care: Consistently complete inpatient consults within the specified timeframe.

Computed Tomography Radiation Monitoring: Document the radiation dose in the Computerized Patient Record System.

Advance Directives: Consistently use appropriate note titles to document advance directive screening. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives. Consistently use the required advance directive note titles.

Emergency Airway Management: Ensure clinicians reassessed for continued emergency airway management scope of practice have a statement related to emergency airway management included in the scope of practice. Require that a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care.

Follow-Up on Quality Management: Consistently perform continuing stay reviews on at least 75 percent of patients in acute beds.

Comments

The Interim Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–32, for the full text of the Directors' comments.) We consider recommendation 14 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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 eight activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Surgical Complexity
- EAM
- Follow-Up on QM

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

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through August 17, 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 Central Arkansas Veterans Healthcare System, Little Rock, Arkansas,* Report No. 13-00277-134, March 15, 2013). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 344 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 665 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.

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.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Ten months of Cardiopulmonary Resuscitation Subcommittee meeting minutes reviewed: • The committee did not review each episode.	**1.** We recommended that the Cardiopulmonary Resuscitation Subcommittee review each code episode.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Operating Room Management Council only met nine times over the past 12 months. Nine months of Operating Room Management Council meeting minutes reviewed: • The Chief of Staff and Surgical Quality Nurse were not members. • The council did not review National Surgical Office reports. Several surgical deaths that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • The Operating Room Management Council did not review any of these deaths.	**2.** We recommended that the Operating Room Management Council meet monthly, include the Chief of Staff and Surgical Quality Nurse as members, and document its review of National Surgical Office reports. **3.** We recommended that the Operating Room Management Council review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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. • 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 emergency management.[b]

At the Little Rock division, we inspected a medical intensive care unit; three medical and/or surgical units; the Emergency Department; and the women's health, dental, and eye outpatient clinics. At the North Little Rock division, we inspected the MH inpatient/psychiatric intensive care unit, two community living center units, and two primary care clinics. We also performed perimeter inspections of two Little Rock and one North Little Rock construction sites. Additionally, we reviewed relevant documents, including 20 employee training and competency records (10 Little Rock division and 10 North Little Rock division), and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Six months of Infection Prevention and Control Sub-Committee meeting minutes reviewed: • Minutes did not reflect follow-up on actions implemented to address identified problems.	**4.** We recommended that the Infection Prevention and Control Sub-Committee document follow-up on actions implemented to address identified problems.
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Three of 13 patient care areas inspected were not clean. • Bedside stands in two of 13 patient care areas were dirty. • Two of 13 patient care areas contained damaged furniture.	**5.** We recommended that facility managers ensure patient care areas are clean and monitor compliance. **6.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service.
	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 SCI Center		
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.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	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.	• Four of the applicable 16 designated employees did not have evacuation device training in accordance with facility policy.	**7.** We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.
	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.		
	Areas Reviewed for Construction Safety		
	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		

NM	Areas Reviewed for Construction Safety (continued)	Findings	Recommendations
	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 the surgical intensive care, post-anesthesia care, and medical/surgical units and the Emergency Department and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
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.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include training and minimum competency requirements for users.	**8.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include training and minimum competency requirements for users and that facility managers monitor compliance.
	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.		
	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 31 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. 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
	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		
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Consultants did not complete seven of the applicable 28 consult requests within the specified timeframe.	**9.** We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.
	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.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 10 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. 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 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: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • 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 • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

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.		
X	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.	Local policy and procedure reviewed: • Although required by local policy, radiologists did not document the radiation dose in the Computerized Patient Record System for 10 patients (21 percent).	**10.** We recommended that radiologists document the radiation dose in the Computerized Patient Record System and that facility managers monitor compliance.
	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.		
	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.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 42 randomly selected patients who had an acute care admission January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
X	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.	• Thirty-five of the 42 EHRs (83 percent) did not contain appropriate screening note titles.	**11.** We recommended that employees consistently use appropriate note titles to document advance directive screening and that facility managers monitor compliance.
NA	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Seven of the 42 EHRs (17 percent) did not contain documentation that employees asked patients whether they wished to discuss creating, changing, and/or revoking ADs. • For six of the 11 AD discussion notes, employees did not use the required note titles.	**12.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance. **13.** We recommended that employees consistently use the required advance directive note titles and that facility managers monitor compliance.
	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.[g]

We reviewed relevant documents and the training records of 15 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

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

We reviewed relevant documents, including competency assessment documentation of nine clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	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 nine clinicians had statements related to EAM included in the scope of practice.	**14.** We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have a statement related to emergency airway management included in the scope of practice.
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	• None of the 30 sampled days had EAM coverage during all hours the facility provided patient care.	**15.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity with Previous CAP Recommendation

Follow-Up on QM

As a follow-up to a recommendation from our previous CAP review, we reassessed facility compliance with performing continuing stay reviews.[i]

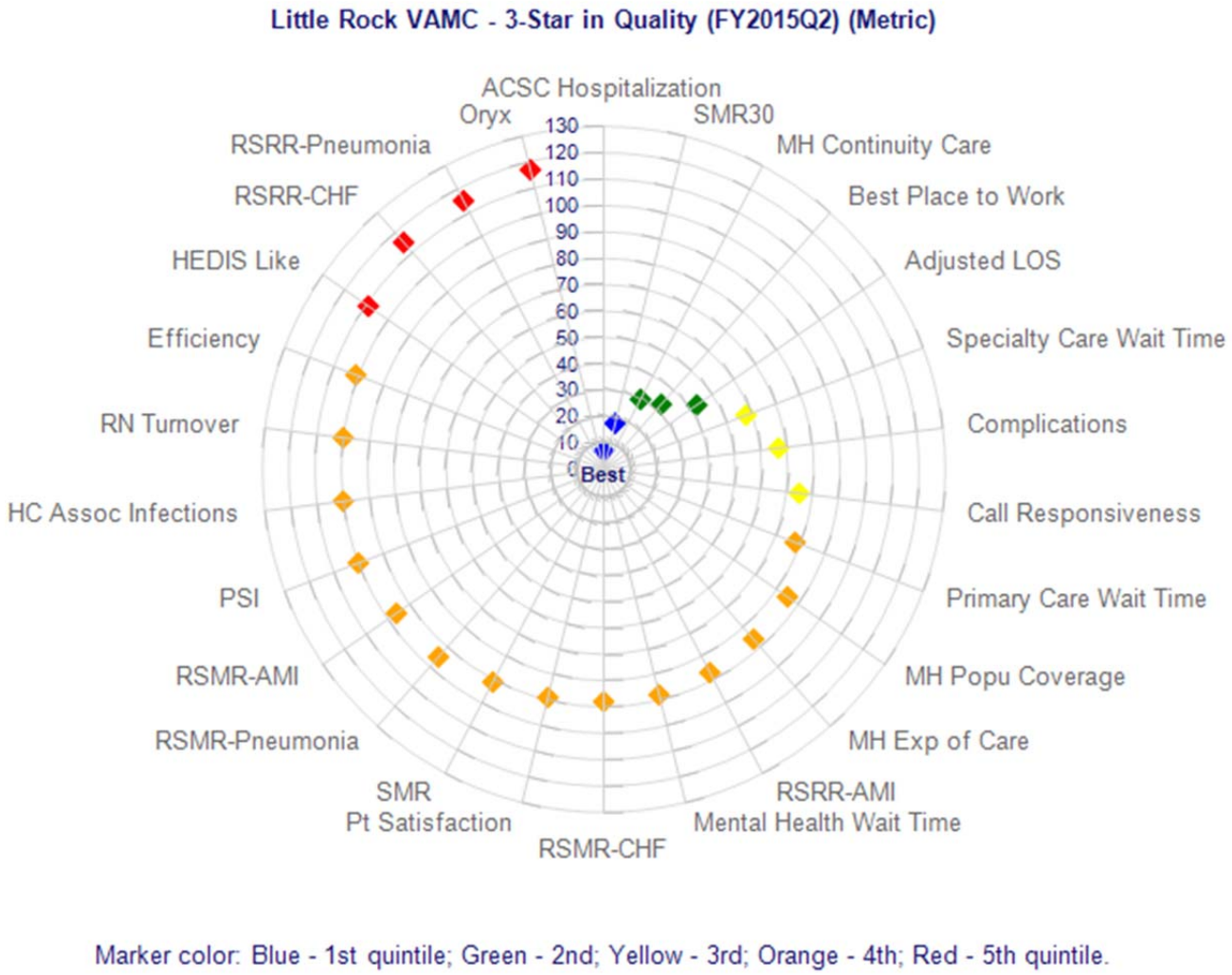
Continuing Stay Reviews. VHA requires staff to perform continuing stay reviews on at least 75 percent of patients in acute beds. We reviewed the percentage of continuing stay reviews performed per month during the previous 12 months. For 7 of the 12 months, the facility reviewed less than 75 percent of acute inpatients.

Recommendation 16. We recommended that the facility consistently perform continuing stay reviews on at least 75 percent of patients in acute beds.

Facility Profile (Little Rock/598) FY 2015 through July 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$542.7
Number of:	
• **Unique Patients**	74,863
• **Outpatient Visits**	720,569
• **Unique Employees**[2]	2,873
Type and Number of Operating Beds:	
• **Hospital**	255
• **Community Living Center**	152
• **MH**	119
Average Daily Census:	
• **Hospital**	167
• **Community Living Center**	96
• **MH**	107
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Mountain Home/598GA El Dorado/598GB Hot Springs/598GC Mena/598GD Pine Bluff/598GE Searcy/598GF Conway/598GG Russellville/598GH
VISN Number	16

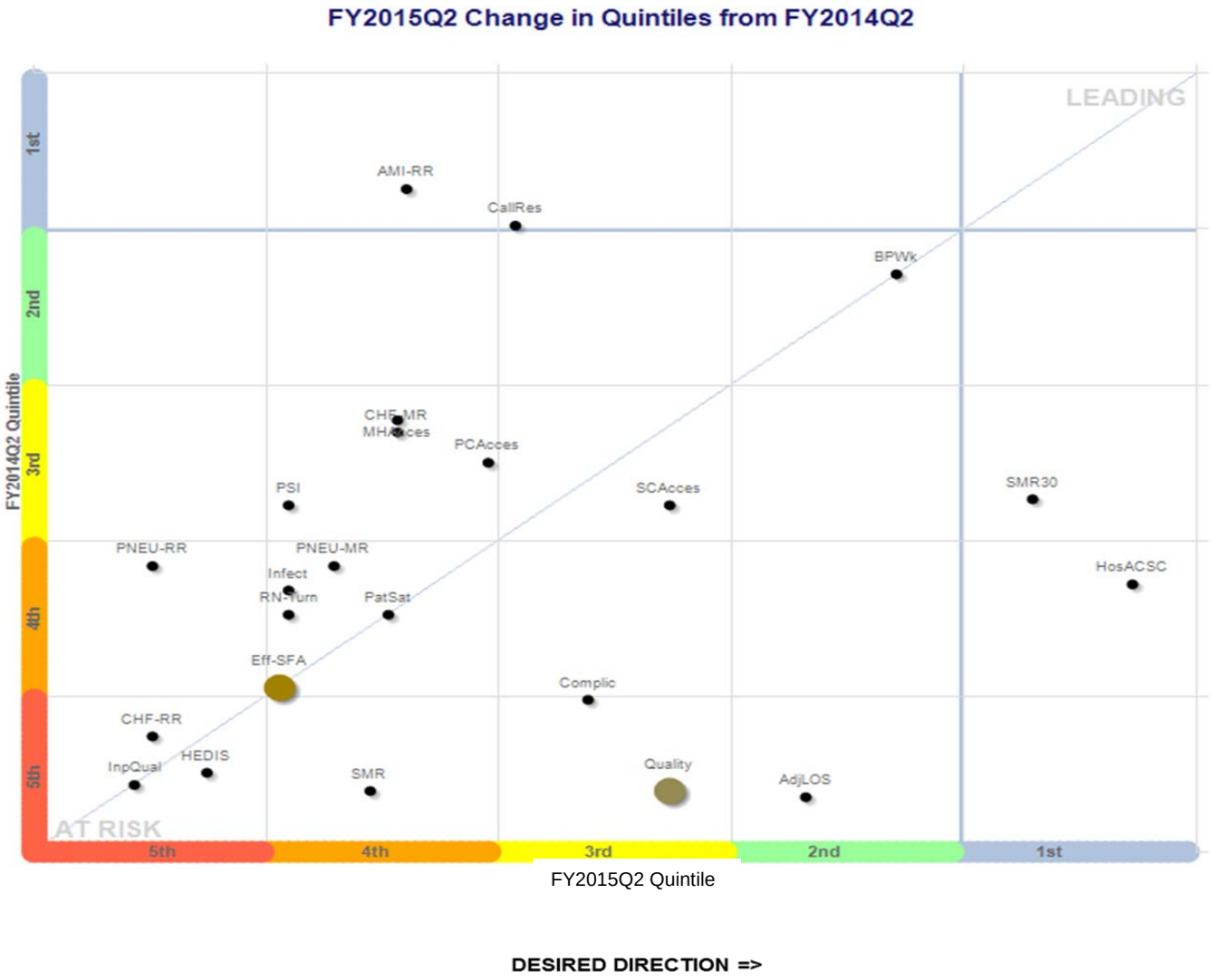
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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.

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

Interim VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: September 29, 2015

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

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

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

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

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

2. If you have any questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist at (601) 206-7022.

Fernando Rivera, FACHE
Interim Director
South Central VA Health Care Network (10N16)

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 16, 2015

From: Interim Director, Central Arkansas Veterans Healthcare System (598/00)

Subject: **CAP Review of the Central Arkansas Veterans Healthcare System, Little Rock, AR**

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

I have reviewed and concur with the action plans regarding the Combined Assessment Program Review conducted at the Central Arkansas Veterans Healthcare System.

Cyril O. Ekeh, MHA, VHA-CM
Interim Medical Center Director,
Central Arkansas Veterans Healthcare System (598/00)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Cardiopulmonary Resuscitation Subcommittee review each code episode.

Concur

Target date for completion: January 30, 2016

Facility response: The Cardiopulmonary Resuscitation Committee will review each code episode and document the review in the meeting minutes. Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 2. We recommended that the Operating Room Management Council meet monthly, include the Chief of Staff and Surgical Quality Nurse as members, and document its review of National Surgical Office reports.

Concur

Target date for completion: January 30, 2016

Facility response: Beginning August 27, 2015 the ORMC/Facility Surgical Work Group continues to meet monthly. Membership now includes the Chief Of Staff and the VA Surgical Quality Improvement Program (VASQIP) Nurse(s). The VASQIP Nurse present will provide a review of the National Surgery Office (NSO) quarterly report(s) and any other pertinent VASQIP information or data.

Review of meeting minutes and attendance, including Chief of Surgery, Chief of Staff, OR Nurse Manager, and VA Surgical Quality Improvement Nurse(s). Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 3. We recommended that the Operating Room Management Council review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: January 30, 2016

Facility response: Beginning September 10th, 2015, the Associate Chief of Staff – Surgery and Anesthesia will bring forward any surgical deaths with identified problems and/or opportunities for improvement that have been identified through M&M or ORMC (Facility Surgical Work Group – FSWG) for additional review/discussions. These will be documented in the ORMC minutes. Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 4. We recommended that the Infection Prevention and Control Sub-Committee document follow-up on actions implemented to address identified problems.

Concur

Target date for completion: March 30, 2016

Facility response: Infection Control will improve committee minutes to include actions taken and ensure closure. Infection Control and QM will review the meeting minutes and advice on closure and follow-up documentation of items. Monitoring will begin with the October 2015 meeting (the committee meets every other month on even months), and will continue until 90% compliance for a minimum of three (3) consecutive meetings is met.

Recommendation 5. We recommended that facility managers ensure patient care areas are clean and monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: 1. Upon notification of the findings during survey, Environmental Management Services (EMS) corrected the issue specific to Mental Health 3K Psychiatric Intensive Care Unit. During the OIG inspection, it was noted that part of the cleaning issues identified were due to areas under construction. The E.D. floors and patient care areas have been placed on a cleaning schedule.

2. EMS Supervisors will continue utilizing the Checklist already in place at CAVHS to monitor cleaning of patient care areas. The compliance will be reported to Quality Management monthly and to the Accreditation Oversight Review Committee, the Quality Safety and Value Board via the Accreditation Dashboard. Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 6. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: January 30, 2016

Facility response: 1. Reeducation of staff regarding the mechanism for requesting damaged furniture removal from patient care areas occurred via the CAVHS Insider the week of September 10, 2015.

2. EMS Supervisors will continue utilizing the Furniture Checklist to monitor requests for removal of furniture from patient care areas. The percent of compliance will be reported to Quality Management monthly and to the Accreditation Oversight Review Committee, via the Accreditation Dashboard. Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 7. We recommended that facility managers ensure designated employees receive evacuation device training and monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: All current CAVHS designated employees will complete training by viewing the 'Evac U Sled' video, from the manufacturer, available on TMS. New designated nursing employees currently receive training during Nursing Orientation. New designated employees will receive training during New Employee Orientation, beginning November 1, 2015. Compliance will be monitored until 100% of designated staff has received the training.

Recommendation 8. We recommended that the facility revise the policy for safe use of automated dispensing machines to include training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: The facility policy was updated to include end-users (nurses) with the following verbiage.

"c. The supervisory pharmacist is responsible for pharmacy personnel training and documenting competency for operating and maintaining the units. Automation competency for appropriate dispensing units will be included in the competency for each technician and pharmacist assigned to the pharmacy."

"d. The unit nurse manager is responsible for nursing personnel training and documenting competency for operating the units. Automation competency for appropriate nursing personnel will be included in the competency for each nursing staff member assigned to use the automation."

Recommendation 9. We recommended that consultants consistently complete inpatient consults within the specified timeframe and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: Medical Center Memorandum 11-84, Consult Policy and Procedure, was revised September 14, 2015 to state that all routine consults (inpatient and outpatient) will be seen based on the clinically indicated date requested by the provider. Also, a stat consult requires a discussion between the referring and receiving providers to determine when the patient should be seen. The VSSC Consult List will be used and the filter 'inpatient consults' applied in order to retrieve 30 random consults per month. A minimum of 30 clinical consults per month will be audited until a 90% compliance rate has been achieved for three consecutive months. This will be reported to facility leadership through the Consult Management and Oversight Committee.

Recommendation 10. We recommended that radiologists document the radiation dose in the Computerized Patient Record System and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: CT dosimetry by protocol is automatically electronically attached to each study through VISTA IMAGING and is available in the CPRS. The facility policy has been updated. CT dosimetry records in CPRS will be monitored for outliers monthly until a 90% compliance rate has been achieved for three (3) consecutive months.

Recommendation 11. We recommended that employees consistently use appropriate note titles to document advance directive screening and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: Applicable staff will be provided re-education on the specific requirements for advance directive screening and documentation using the appropriate note titles. 50 chart audits will be completed monthly until a 90% compliance rate has been achieved for three (3) consecutive months.

Recommendation 12. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: Applicable staff will be provided re-education on the specific requirement to ask inpatients whether they would like to discuss creating, changing, and/or revoking an advance directive. 50 chart audits will be completed monthly until a 90% compliance rate has been achieved for three (3) consecutive months.

Recommendation 13. We recommended that employees consistently use the required advance directive note titles and that facility managers monitor compliance.

Concur

Target date for completion: January 30, 2016

Facility response: Applicable staff will be provided re-education on the specific requirements for advance directive documentation using the appropriate note titles. 50 chart audits will be completed monthly until a 90% compliance rate has been achieved for three (3) consecutive months.

Recommendation 14. We recommended that the facility ensure that clinicians reassessed for continued emergency airway management scope of practice have a statement related to emergency airway management included in the scope of practice.

Concur

Target date for completion: September 1, 2015

Facility response: During a called meeting of the Medical Staff, the Respiratory Therapy supervisor, the Chief of Medicine, and the Acting Chief of Staff approved a scope of practice for Respiratory Therapists. Additionally, the Credentialing and Privileging Committee approved the SOP for all therapists that have been deemed competent for Out of O.R. Airway Management. All therapists have signed this new SOP.

Status: We request closure of this recommendation based on the evidence provided above.

Recommendation 15. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Although trained and competent staff were available during all hours that the facility provides patient care, the respiratory therapists who were included in the staff that provided the service had functional statements and not scopes of practice. While the OIG were on site, scopes of practice were developed for each of the respiratory therapists and approved by the Credentialing and Privileging Committee. Monthly review will continue until a compliance rate of 90% or greater is achieved for three (3) consecutive months.

Recommendation 16. We recommended that the facility consistently perform continuing stay reviews on at least 75 percent of patients in acute beds.

Concur

Target date for completion: January 30, 2016

Facility response: Utilization Management will send the number of reviews completed to respective chiefs weekly. A fee-based consultant will assist with education for coordinators and guidance in performing reviews. A monthly VSSC report on continued stays will be submitted to Quality Safety and Value Committee until 75% of continued stay reviews are achieved for three (3) consecutive months.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Larry Ross, MS, Team Leader Shelia Farrington-Sherrod, RN, MSN Rose Griggs, MSW, LCSW Gayle Karamanos, MS, PA-C Cathleen King, MHA, CRRN Trina Rollins, MS, PA-C, James Werner, Special Agent In Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Julie Watrous, RN, MS Jarvis Yu, MS

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U.S. Senate: John Boozman, Tom Cotton
U.S. House of Representatives: Rick Crawford, French Hill, Bruce Westerman, Steve Womack

This report is available at **www.va.gov/oig**.

Endnotes

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

[b] References used for this topic included:
- VHA Directive 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.

[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 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.

[f] 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.

[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] The reference used for this topic was:
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.