Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-02414-82

Combined Assessment Program Review of the Robert J. Dole VA Medical Center Wichita, Kansas

March 3, 2009

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of December 8–12, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Robert J. Dole VA Medical Center (the medical center), Wichita, KS. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 145 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- Duty to report software program.
- Root cause analysis (RCA) teams.

We made recommendations in six of the activities reviewed. For these activities, the medical center needed to:

- Ensure that all medical center employees who require cardiopulmonary resuscitation (CPR) training and automated external defibrillator (AED) training have current certification.
- Modify the local CPR policy to include all employees that require training and define the process for tracking current training.
- Maintain medication refrigerator cleanliness in accordance with local policy.
- Modify the local hand hygiene practice policy to include all Veterans Health Administration (VHA) requirements and provide health care workers with information regarding their performance.
- Ensure that staff are aware of hazardous spill procedures.
- Monitor and test the electronic elopement system according to the manufacturer's recommendations.
- Assure the safe use of electrical appliances.
- Complete intra-facility transfer documentation, as required by local policy.

- Complete discharge documentation, as required by Joint Commission (JC) standards and local policy.
- Complete emergency department (ED) inter-facility transfer documentation, as required by VHA and local policy.
- Document the effectiveness of all pain medications within the timeframe required by local policy.
- Ensure that the medical center's Director initiates and signs appointment letters for the alternate Controlled Substances Coordinator (CSC) and controlled substances inspectors.

The medical center complied with selected standards in the following two activities:

- Staffing.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and James Seitz, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is located in Wichita, KS, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics in Parsons, Hutchinson, Salina, Hays, Ft. Dodge, and Liberal, KS. The medical center is part of VISN 15 and serves a veteran population of about 100,500 throughout 59 counties in Kansas. Fourteen of these counties are designated as Health Professional Shortage Areas (HPSA) for primary care, and 57 of these counties are designated as HPSA for mental health.

Programs. The medical center provides a full range of primary, specialty, acute, and extended care services. It has 41 hospital beds and 40 community living center (CLC) beds.[1]

Affiliations and Research. The medical center is affiliated with the University of Kansas' School of Medicine-Wichita and supports 23 medical resident training positions. Also, the medical center has developed an affiliation with Wichita State University for dental and nursing students. In fiscal year (FY) 2008, the medical center research program had nine projects and a budget of approximately $6,000. Important areas of research include web-based training on basic skin cancer triage and pulmonary studies.

Resources. In FY 2008, medical care expenditures totaled $109 million. The FY 2009 medical care budget is $112 million. FY 2008 staffing was 823 full-time employee equivalents (FTE), including 44 physician and 259 nursing FTE.

Workload. In FY 2008, the medical center treated 27,875 unique patients and provided 9,203 inpatient days in the hospital and 13,426 inpatient days in the CLC. The inpatient care workload totaled 2,165 discharges, and the average daily census, including CLC patients, was 62. Outpatient workload totaled 515,296 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

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 administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Pharmacy Operations.
- QM.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007, FY 2008, and FY 2009 through November 29, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Veterans Health Administration Activities at the Robert J. Dole VA Medical Center, Wichita, Kansas,* Report

No. 05-03277-121, March 31, 2006). The medical center had corrected all findings related to health care from the prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 145 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.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Duty to Report Software Program

A team from the medical center developed a reportable incident software program that is available to all employees by clicking an icon on any medical center computer. The purpose of the program is to make it easier for employees to report any actual or suspected event, concern, or vulnerability that could pose a threat to veterans, staff, or stakeholders. Every employee is encouraged to report incidents in order to improve systems, processes, and EOC.

When an employee becomes aware of a potential or actual incident, he/she is to submit a computerized report. Categories of reports include patient safety; hazards (including infection control (IC) concerns); compliance, business integrity, and conflict of interest; security and privacy; equal employment opportunity and sexual harassment; Hatch Act and whistleblower protection; JC; coding, billing, and medical documentation; ethics; and time and attendance and travel. Although employees may remain anonymous, medical center managers have encouraged identity disclosure to make follow-up possible.

Each category has a unique report format. Upon completion, reports are forwarded via e-mail to the person responsible for that program. Program managers enter data onto spreadsheets, and the data is simultaneously displayed graphically on a shared drive. This comprehensive software program has helped to significantly increase the number of reported incidents, resulting in process improvements.

Root Cause Analysis Teams

During our prior CAP review, we noted a problem with completion of required aggregate and special RCAs. The Patient Safety Coordinator initiated a change in the process that resulted in the timely completion of all RCAs during the last 12 months.

For each of the major RCA reporting categories, a team leader and team members were appointed for a 1-year period. Staff from the VA National Center for Patient Safety came to the medical center to train the teams. This has eliminated the need to search for available staff and train them when an RCA is required, thus saving valuable time. If the RCA team recommends a process action team (PAT), a member of the RCA team serves on the PAT for continuity. Since the process was changed, RCAs have provided meaningful recommendations that have improved patient care and safety.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Managers had corrected findings from the prior CAP review and had made significant improvements. Appropriate review structures were in place for 13 of the 14 program activities reviewed. We identified the following area that needed improvement:

Cardiopulmonary Resuscitation Training. Police officers did not have current training. Medical center police vehicles are equipped with an AED, and VHA requires that police officers have current CPR and AED training. VA policy[2] requires that orientation and mandatory yearly in-service training programs for VA police officers include a CPR course conducted by a certified instructor. CPR courses include

[2] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

AED training. Although all 11 officers had received initial training, 10 (91 percent) had not renewed their training certifications when they expired.

Also, the local policy that defines which medical center employees are required to maintain current CPR certification does not include police officers. Additionally, the policy does not define the process for tracking current training.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that all medical center employees who require CPR and AED training have current certification.

The VISN and Medical Center Directors concurred with our finding and recommendation. Police Service staff are in the process of renewing their certifications. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the local CPR policy is modified to include all employees who require training and to define the process for tracking current training.

The VISN and Medical Center Directors concurred with our findings and recommendation. Education Service is reviewing the local CPR policy and is developing a tracking system for training. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Environment of Care

The purpose of this review was to determine if VHA medical centers maintain a safe and clean environment. Medical centers are required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards.

We inspected outpatient areas, the inpatient medical and surgical units, the intensive care unit (ICU), the telemetry unit, and the CLC. Also, we reviewed the IC program. The medical center maintained a generally clean and safe environment. Nurse managers and unit staff expressed satisfaction with the responsiveness of the housekeeping staff on their units. We identified the following areas that needed improvement:

Medication Refrigerator Monitoring. Staff did not consistently clean medication refrigerators weekly to maintain sanitary cold storage, as required by local policy. Two of three medication refrigerators were not clean, and unit managers had not developed a system to monitor cleaning.

Hand Hygiene. The local hand hygiene policy did not include all VHA requirements. VHA requires[3] that the local policy include the requirement that the medical center monitor health care workers' hand hygiene adherence and provide them with information regarding their performance in order to reduce infection risks for patients and staff. IC staff placed overall hospital compliance percentages on a shared drive, but information was not unit or individual specific. Health care staff that we interviewed rarely accessed the shared drive and were not aware of their performance.

Hazardous Spill Containment. During interviews, staff on two units were unable to correctly verbalize the local policy on actions to take in the event of a hazardous spill, such as blood. Unit managers need to ensure that staff are educated about proper hazardous spill procedures.

Safety. Facility Management Service staff had not performed a system maintenance test for the electronic patient elopement system—used to alert staff that high-risk patients have left their unit without supervision—since 2004. Health care staff did not test the monitored doors or sensors in accordance with the manufacturer's recommendations to ensure that the system was working. Without appropriate testing, staff could not be assured that the system was functional.

Electrical Hazards. The medical center environmental rounds team conducted weekly environmental rounds as required by VHA. However, we found a compact disc player plugged into an electrical outlet and suspended by a string over a whirlpool bathtub. Also, we found a coffee pot and a microwave oven plugged into an extension cord that was plugged into an adapter and then into an electrical outlet. Practices like these can lead to electrical injuries and create fire hazards. These electrical hazards had not been identified during environmental rounds.

[3] VHA Directive 2005-002, *Required Hand Hygiene Practices*, January 13, 2005.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires staff to maintain medication refrigerator cleanliness in accordance with local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. Local policy has been revised to include cleaning timeliness, and staff have been educated on the policy and process. Also, a monitor for refrigerator cleaning is in place. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the local hand hygiene policy includes a requirement to monitor health care workers' adherence to hand hygiene practices and that health care workers are provided with information regarding their performance.

The VISN and Medical Center Directors concurred with our findings and recommendation. The local policy is being revised, and supervisors are now responsible for sharing hand hygiene performance results with staff. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that staff are aware of the procedures to follow in the event of a hazardous spill.

The VISN and Medical Center Directors concurred with our findings and recommendation. Information has been provided to staff to re-educate them on response procedures for hazardous spills. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that staff monitor and test the electronic elopement system according to the manufacturer's recommendations.

The VISN and Medical Center Directors concurred with our finding and recommendation. Staff are completing daily, weekly, and monthly checks of the elopement system. Preventive maintenance has been scheduled on a quarterly basis in accordance with the manufacturer's

recommendations. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that staff use electrical appliances safely.

The VISN and Medical Center Directors concurred with our findings and recommendation. Staff will be re-educated on electrical safety, and environmental rounds will assess compliance on an ongoing basis. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were coordinated appropriately and met VHA and JC standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process resulting in optimal patient outcomes.

We reviewed the medical records of 15 inpatients who had consults ordered and performed internally. In general, we found that inpatients received consultative services within acceptable timeframes. We identified the following areas that needed improvement:

Transfer Documentation. We found that 4 (27 percent) of 15 intra-facility transfers did not have the required medical record documentation specified by local policy. Two did not include nursing notes, and the other two did not include physician notes. Local policy requires that nursing staff and physicians complete a transfer note each time a patient is transferred within the facility.

Discharge Documentation. We found that 2 (13 percent) of 15 records did not have patient discharge instructions that were consistent with the patient discharge summary. Also, 4 (27 percent) of 15 records did not have discharge education documented by nursing staff. JC standards require individualized patient education prior to discharge, and local policy requires that nursing staff document discharge education for each patient. Documentation and communication of patient health information enhances continuity and coordination of care.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete intra-facility transfer documentation, as required by local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. Templates are in place for documentation of intra-facility transfers. Compliance will be monitored, and results will be reported through the Quality Performance Council. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by JC standards and local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. Supervisors have stressed the importance of using the discharge template for documentation. Use of the template will be monitored, and results will be reported through the Quality Performance Council. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate whether VHA facility E/UC operations complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED for cleanliness and safety.

The ED is located within the main hospital building and is open 24 hours per day, 7 days per week. The emergency services provided are within the medical center's patient care capabilities.

We reviewed medical records of patients who presented in the ED with acute mental health conditions, and in all cases, we found that staff managed the patients' care appropriately. We reviewed the ED nurse staffing plan and time schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing

resources. We also found that managers had appropriately documented nurse competencies.

We determined that the ED complied with VHA operational standards, including staffing guidelines, cleanliness, and competency. However, the following area needed improvement:

Inter-Facility Transfers. ED staff did not document specific inter-facility transfer data, as required by VHA and local policy.[4] The movement of acutely ill patients from one institution to another exposes them to risks. Failing to transfer patients may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately to assure maximum patient safety and to comply with the intent of the Emergency Medical Treatment and Labor Act.

None of the medical records we reviewed contained all the required documentation elements. During onsite interviews, ED staff located and identified their local inter-facility transfer policy, and they provided paper forms that contained all required documentation elements. However, staff stated that they only began using the forms 2 weeks prior to our site visit. We were told that there are plans to develop an electronic inter-facility transfer template.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. ED staff are now using the national template for documentation of inter-facility transfers. Compliance will be monitored. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

[4] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

We reviewed selected medication management processes in the inpatient medical and surgical units, the ICU, the telemetry unit, and the CLC. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to correctly identify patients prior to medication administration. We identified the following area that needed improvement:

Documentation of Pain Medication Effectiveness. On the inpatient units we reviewed, nurses did not consistently document the effectiveness of pain medications in accordance with local policy requirements. We reviewed the Bar Code Medication Administration records for 15 patients who were hospitalized in selected units at the time of our visit. For each patient, we reviewed documentation for several doses of pain medication. Nurses did not consistently document the effectiveness of pain medications within 4 hours in 12 (80 percent) of the 15 patients, as required by local policy. Without appropriate follow-up and consistent documentation, clinicians could not be assured that patients' pain was effectively managed.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

The VISN and Medical Center Directors concurred with our finding and recommendation. The local policy and the documentation template will be reviewed and then modified as needed. Timeliness of documentation will be monitored. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of controlled substances and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We assessed whether the medical center's policies and practices were consistent with VHA regulations governing

pharmacy and controlled substances security.[5] In addition, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy. We inspected inpatient and outpatient pharmacy operations for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service personnel as necessary.

Pharmacy Controls. The medical center had appropriate policies and procedures to ensure the security of the pharmacy and controlled substances. The internal environments for the inpatient and outpatient pharmacies were secure, clean, and well maintained with the exception of the pharmacy vault day gate. The day gate in the pharmacy vault would not close automatically upon entry. Staff had to close the gate manually to engage the lock. VHA requires an automatic closing and locking day gate to ensure the security of bulk controlled substances. Medical center staff repaired the day gate during our review; therefore, we made no recommendation.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[6] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[7] Clinical pharmacists identified all patients who were prescribed multiple medications, reviewed their medication regimens to

[5] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.
[6] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.
[7] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

avoid polypharmacy, and advised providers as appropriate. We identified the following area that needed improvement:

Controlled Substances Inspections. While assigned staff conducted the inspections according to VHA regulations, and training records documented that the CSC, the alternate CSC, and all inspectors received appropriate training to execute their duties, we noted an area of the program that did not meet VHA regulations. The CSC, with approval from the medical center's Director, initiated and signed the controlled substances inspectors' appointment letters. VHA regulations[8] state that medical center Directors have the responsibility to initiate and sign all appointment letters.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director initiates and signs appointment letters for the alternate CSC and controlled substances inspectors.

The VISN and Medical Center Directors concurred with our finding and recommendation. The Medical Center Director reissued the November 2008 appointment letters with his signature. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Review Activities Without Recommendations

Staffing

The purpose of this review was to evaluate whether VHA facilities had developed comprehensive staffing guidelines and whether the guidelines had been met. We found that the medical center had developed a Nursing Service staffing plan and unit-based nurse staffing guidelines, and we found them to be adequate.

The medical center uses staff/patient/acuity ratio as the primary staffing methodology. Nurse managers adjust staffing shift-by-shift based on patient acuity levels; average daily census; and frequency of patient admissions, transfers, and discharges. The Nursing Service staffing plan is reviewed and adjusted annually.

We reviewed staffing for all inpatient units for a total of 27 shifts. We looked at one holiday, one Sunday, and one Tuesday for all units. We found that local guidelines for

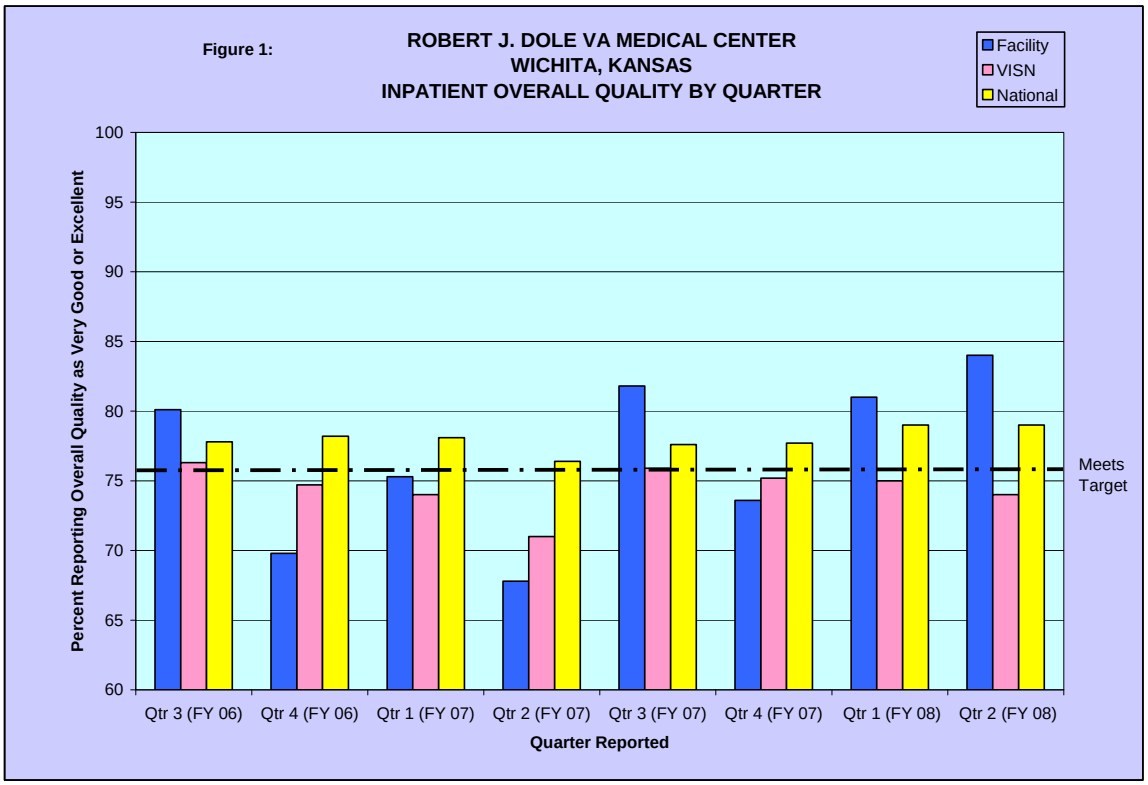
[8] VA Handbook 0730.

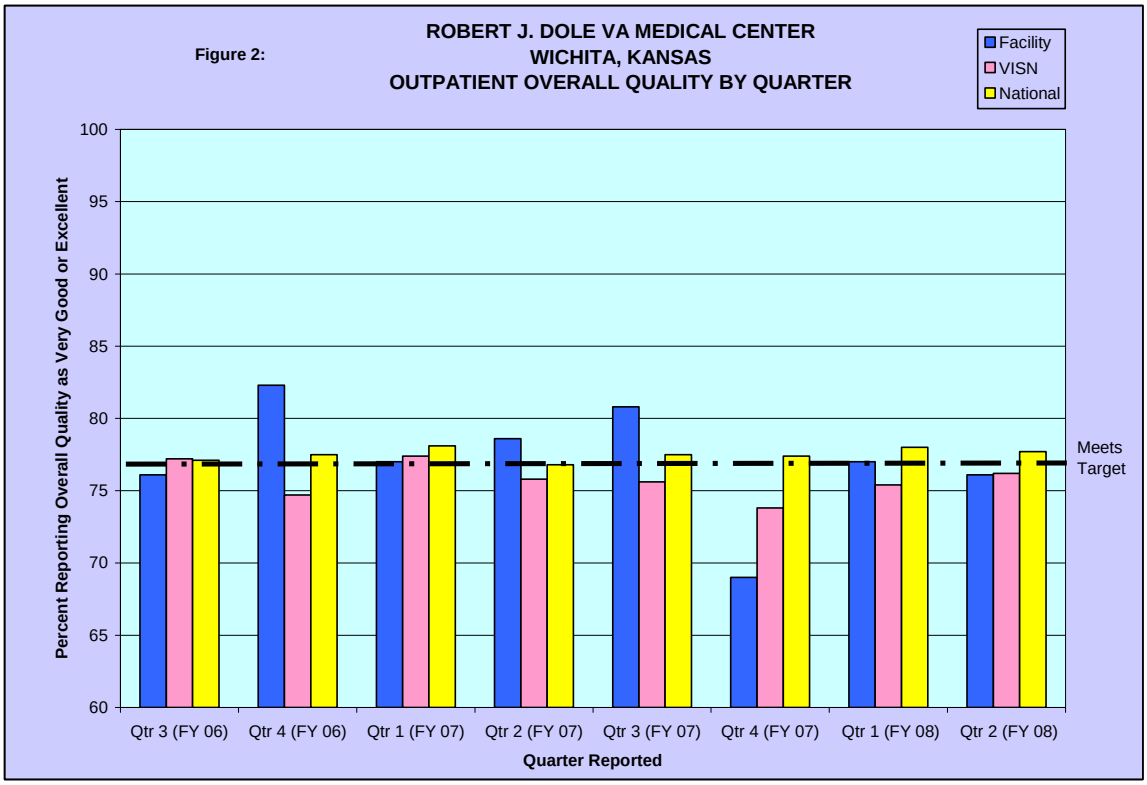
nurse staffing were met in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of compensatory time and overtime when needed. We found nurse staffing adequate in all patient care areas. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use quarterly survey results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Medical centers are expected to address areas that fall below target scores.

We reviewed the inpatient and outpatient survey results for each quarter, beginning with the 3rd quarter of FY 2006 and ending with the 2nd quarter of FY 2008. Figure 1 below and Figure 2 on the next page show the medical center's SHEP performance measure results for inpatients and outpatients, respectively.





The medical center fell below target levels in 4 of the 8 quarters reviewed for inpatient overall quality and 3 of the 8 quarters reviewed for outpatient overall quality. The medical center's Director shared SHEP data with staff, service chiefs, and patients. Communication, coordination of care, and emotional support were identified as areas needing improvement in the inpatient units. The reorganization of primary care, the transfer of responsibility for phone calls to primary care teams, and the 30-day open access for appointments contributed to the decreased outpatient scores. All data was analyzed, actions were taken, and plans were appropriate and effective; therefore, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 4, 2009

From: Director, VA Heartland Network (10N15)

Subject: **Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas**

To: Director, Kansas City Healthcare Inspections Division (54KC)

Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report from the Combined Assessment Program (CAP) review of the Robert J. Dole VA Medical Center, Wichita, Kansas, dated January 23, 3009. I concur with the implementation plans as described and the established target dates.

2. The medical center carefully reviewed all items identified as opportunities for improvement and concurred in the recommendations that were made.

3. If you have additional questions, or need additional information, please contact Mary Steiner at 316.685.2221.

James R. Floyd, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 2, 2009

From: Director, Robert J. Dole VA Medical Center (589A7/00)

Subject: **Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas**

To: Director, VA Heartland Network (10N15)

I concur with the findings and recommendations of the CAP Review.

Tom Sanders

THOMAS J. SANDERS, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that all medical center employees who require CPR and AED training have current certification.

Concur April 1, 2009

In progress. Action has been started for current certification of VA Police staff. Education Service is refining the tracking system for CPR certification. Effectiveness will be monitored.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the local CPR policy is modified to include all employees who require training and to define the process for tracking current training.

Concur April 1, 2009

The local policy is being reviewed to determine clinically active staff, as well as any additional staff that may require CPR training. The process for tracking current CPR is being developed by Education Service. The effectiveness of the tracking system will be monitored.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires staff to maintain medication refrigerator cleanliness in accordance with local policy.

Concur April 1, 2009

The policy for maintenance and cleaning of the patient care refrigerators (including medication refrigerators) has been revised to include cleaning timeliness. Education on the policy and process has been completed. The monitoring for medication refrigerator cleaning is in place.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the local hand hygiene policy includes a requirement to monitor health care workers' adherence to hand hygiene practices and that health care workers are provided with information regarding their performance.

Concur March 1, 2009

The local hand hygiene policy is being reviewed and revised. Monitoring continues to occur and supervisory personnel are responsible (per revised policy) for sharing information with staff on staff performance based on the monitoring results.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that staff are aware of the procedures to follow in the event of a hazardous spill.

Concur March 1, 2009

Policies are currently being reviewed and will be revised for further clarification as needed. A memorandum has been sent to re-educate staff on procedures for response to hazardous spills.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff monitor and test the electronic elopement system according to the manufacturer's recommendations.

Concur June 15, 2009

In progress. Daily, weekly and monthly checks are being completed by staff. Preventive maintenance (PM) is scheduled on a quarterly basis per manufacturer's directions. PM will be reported for two quarters to ensure effectiveness.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that staff use electrical appliances safely.

Concur Re-education by March 1, 2009

Staff will be re-educated on electrical safety. Environmental rounds will assess compliance on an ongoing basis.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete intra-facility transfer documentation, as required by local policy.

Concur June 1, 2009

Transfer templates are being utilized for intra-facility transfer documentation. Education has been given to appropriate staff. Monitoring for compliance will occur and be reported through the Quality Performance Council.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires staff to consistently complete discharge documentation, as required by JC standards and local policy.

Concur June 1, 2009

Use of the discharge template has been re-emphasized by supervisory staff and monitoring of the use and appropriate discharge documentation will be reported to Quality Performance Council.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires ED staff to complete inter-facility transfer documentation, as required by VHA and local policy.

Concur June 1, 2009

The Emergency Department are now consistently using the national template for documentation of inter-facility transfers. Education has been provided to all ED providers. Monitoring will be done for compliance.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses consistently document the effectiveness of all pain medications within the required timeframe of the local policy.

Concur July 1, 2009

The policy and documentation template will be reviewed and modified as needed for possible modification. Monitoring will reflect timeliness per our policy for evaluation of effectiveness of pain medication.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director initiates and signs appointment letters for the alternate CSC and controlled substances inspectors.

Concur Completed

The controlled substances inspector's appointment letters issued in November 2008 were reissued by the Medical Center Director with his signature.

OIG Contact and Staff Acknowledgments

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