Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02069-268

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

September 4, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	John D. Dingell VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
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 July 14, 2014.

Review Results: The review covered seven activities. We made no recommendations in the following activity:

- Coordination of Care

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

Environment of Care: Secure medication carts at all times. Maintain auditory privacy in all intake areas, and stress to staff that sensitive patient information should not be discussed in public areas. Ensure all designed eye clinic employees receive eye laser safety training with the frequency required by local policy.

Medication Management: Document patient/caregiver understanding of discharge instructions.

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

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Modify restorative nursing interventions as needed, and document the modifications. Document the reasons for not providing restorative nursing services when those services are care planned. Ensure hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy. Require that staff who perform restorative nursing services receive training on range of motion and resident transfers. Document residents' restorative progress weekly.

Magnetic Resonance Imaging Safety: Conduct initial patient safety screenings. Ensure radiologists and/or Level 2 magnetic resonance imaging personnel document resolution of all contraindications prior to the scan. Require that all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific

magnetic resonance imaging safety training. Regularly test two-way communication devices.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, page 20–29, for the full text of the Directors comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- QM
- EOC
- Medication Management
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI Safety

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 FYs 2011–2013 and FY 2014 through July 14, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations

we made in our previous CAP report (*Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan,* Report No. 12-02600-28, November 8, 2012).

During this review, we presented crime awareness briefings for 144 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 305 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results and Recommendations

QM

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

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. 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
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing 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. • Data were collected that measured performance in responding to events.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Eight months of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Anesthesia Service attended only two of eight meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendation

1. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

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 and whether the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected the emergency department, the CLC, the intensive care unit, the inpatient MH unit, the medical unit, the surgical unit, SDS, the PACU, and the eye clinic. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 31 employee training records (16 SDS, 10 PACU, and 5 eye clinic). 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
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
X	Medication safety and security requirements were met.	• There were unlocked medication carts in three of six patient care areas.
X	Auditory privacy requirements were met.	• The intake area in one of six patient care areas did not have sufficient auditory privacy, and sensitive patient information was discussed in a facility public area.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SDS and the PACU	
	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	

NM	Areas Reviewed for SDS and the PACU (continued)	Findings
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
X	Designated eye clinic employees received laser safety training with the frequency required by local policy.	• Two of the five eye clinic employees did not receive laser safety training with the frequency required by local policy.
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

2. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that auditory privacy is maintained in all intake areas, that managers stress to staff that sensitive patient information should not be discussed in public areas, and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that all designated eye clinic employees receive eye laser safety training with the frequency required by local policy and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
X	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	• Eight EHRs (24 percent) did not reflect that patients/caregivers understood discharge instructions.
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

5. We recommended that processes be strengthened to ensure that clinicians document patient/caregiver understanding of discharge instructions and that compliance be monitored.

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 29 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. 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
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Acute Ischemic Stroke Care

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

We reviewed relevant documents, the EHRs of 31 randomly selected patients who experienced stroke symptoms, and 15 staff training records (5 emergency department, 5 intensive care unit, and 5 medical and step-down unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department/urgent care unit, one critical care unit, and two acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• Twenty-five EHRs (81 percent) did not contain documented evidence of completed stroke scales.
	Clinicians provided tissue plasminogen activator timely to halt the stroke and included all required steps, and tissue plasminogen activator was in stock or available within 15 minutes.	
	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• Fifteen EHRs (48 percent) did not contain documentation that patients were screened for difficulty swallowing prior to oral intake.
X	Clinicians provided printed stroke education to patients upon discharge.	• Fourteen EHRs (45 percent) did not contain documentation that stroke education was provided to the patient/caregiver.
X	The facility provided training to staff involved in assessing and treating stroke patients.	• Two employees had not completed the web-based training required by the facility.
	The facility collected and reported required data related to stroke care.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

6. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

8. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

9. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 14 EHRs of residents (10 residents receiving restorative nursing services and 4 residents not receiving restorative nursing services but candidates for services). We also observed 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key 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
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• None of the 10 applicable EHRs contained documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• Neither of the two applicable EHRs contained evidence that facility staff documented that interventions were modified to promote the residents' accomplishment of goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• None of the 10 applicable EHRs where restorative nursing services were care planned but were not provided reflected the reasons.
X	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	• Neither of the two EHRs of residents who were discharged from one of the therapies reflected hand-off communication.
X	Training and competency assessment were completed for staff who performed restorative nursing services.	• Two employee training records did not contain evidence of completed training for range of motion and resident transfers.
X	The facility complied with any additional elements required by VHA or local policy.	Local policy on restorative care program for CLC residents reviewed: • Although local policy required weekly documentation of residents' restorative progress, 4 of the 10 applicable EHRs lacked these weekly notes.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
NA	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that staff modify restorative nursing interventions as needed and document the modifications and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that staff document the reasons for not providing restorative nursing services when those services are care planned and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy to ensure that restorative nursing services occur.

14. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on range of motion and resident transfers.

15. We recommended that processes be strengthened to ensure that staff document residents' restorative progress weekly and that compliance be monitored.

MRI Safety

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

We reviewed relevant documents and the training records of 39 employees (27 randomly selected Level 1 ancillary staff and 12 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 34 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of two MRI areas. 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
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
X	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member or caregiver and reviewed and signed by a Level 2 MRI personnel.	• Twenty-two EHRs (65 percent) did not contain initial patient safety screenings.
X	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Eighteen of the 21 applicable EHRs did not contain documentation that all identified contraindications were addressed prior to MRI.
X	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	• None of the Level 1 ancillary staff received level-specific annual MRI safety training. • Five Level 2 MRI personnel did not receive level-specific annual MRI safety training.
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
X	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	• In one of two MRI suites, facility staff did not regularly test the two-way communication device.
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	

NM	Areas Reviewed (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

16. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

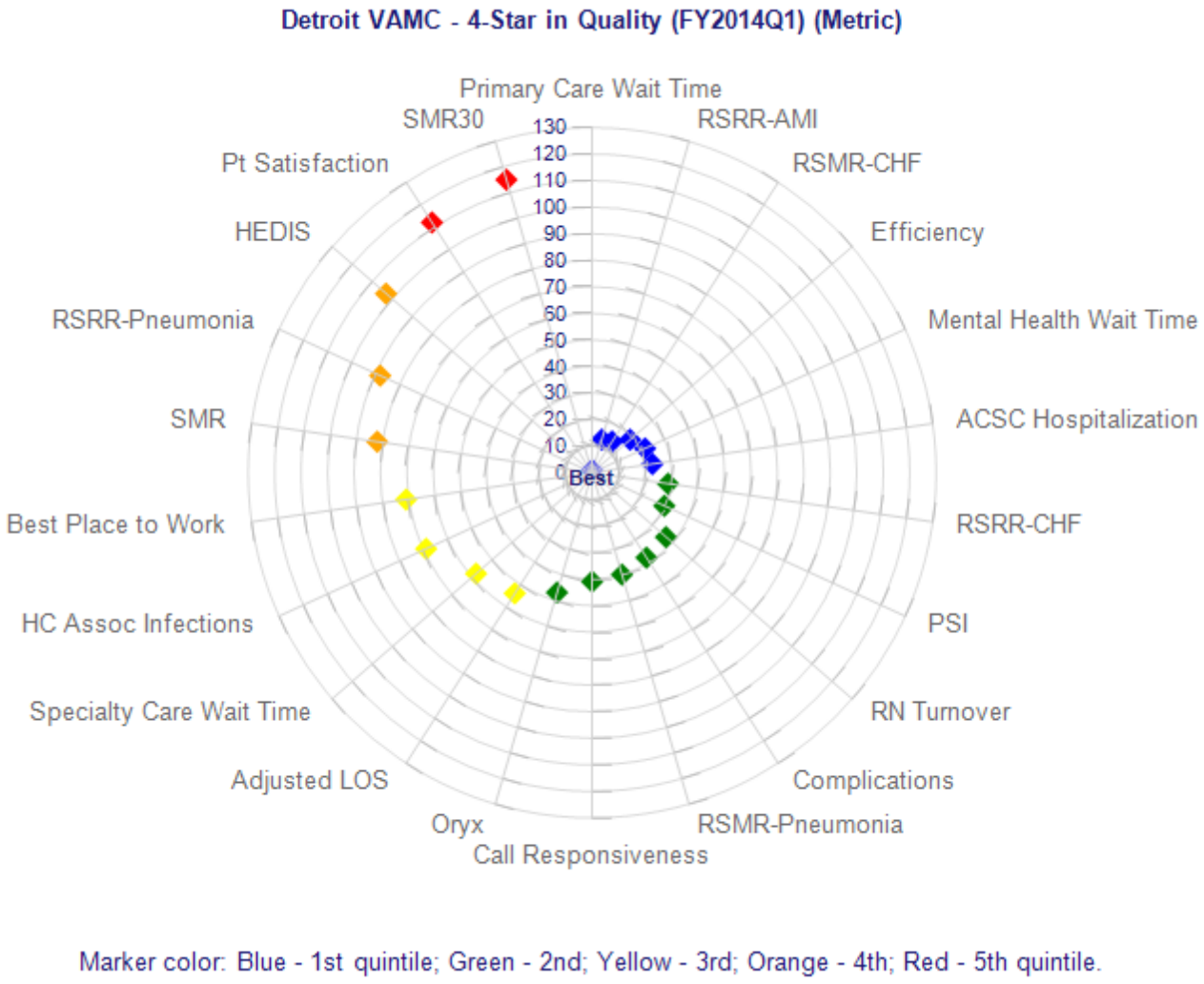
18. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

19. We recommended that processes be strengthened to ensure that two-way communication devices are regularly tested and that compliance be monitored.

Facility Profile (Detroit/553) FY 2014 through June 2014[1]	
Type of Organization	Secondary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$315.2
Number (as of July 2014) of:	
• **Unique Patients**	44,454
• **Outpatient Visits**	399,765
• **Unique Employees**[2]	1,530
Type and Number of Operating Beds:	
• **Hospital**	100
• **CLC**	109
• **MH**	50
Average Daily Census:	
• **Hospital**	60
• **CLC**	69
• **MH**	35
Number of Community Based Outpatient Clinics	2
Location(s)/Station Number(s)	Yale/553GA Pontiac/553GB
VISN Number	11

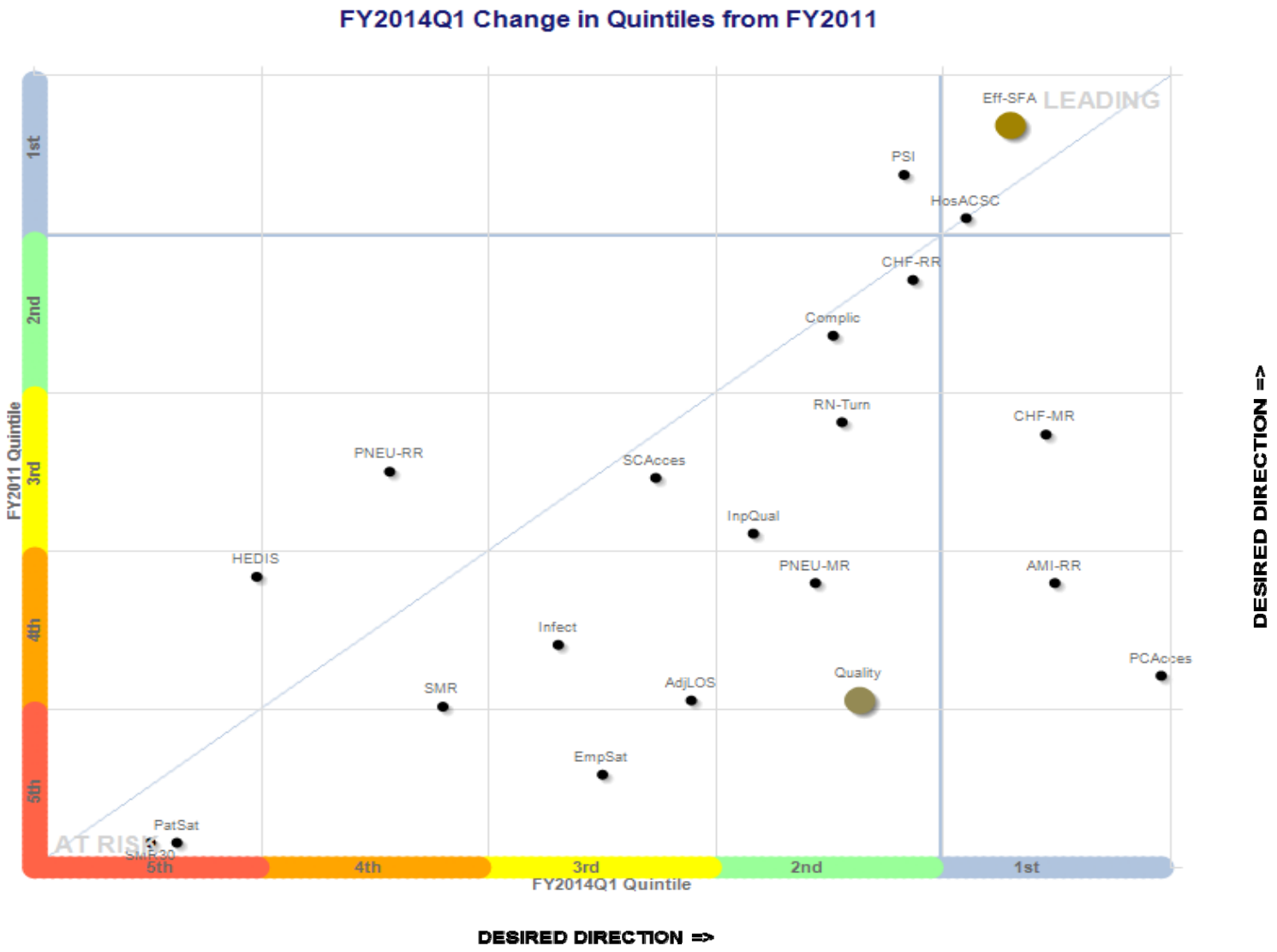
[1] All data is for FY 2014 through June 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

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



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	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
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2014

From: Director, Veterans In Partnership (10N11)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

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

1. Per your request, attached is the response to the draft CAP report for the John D. Dingell VA Medical Center. I have reviewed the comments and concur with the responses and actions to the recommendations in the report.

2. If you have any questions, please contact Carol Jones, Chief Quality, Safety and Values Officer, Veterans In Partnership, VISN 11 at 734-222-4302.

Paul Bockelman

Paul Bockelman, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2014

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Veterans In Partnership (10N11)

1. Thank you for the opportunity to review the draft Office of Inspector General's report on the John D. Dingell VA Medical Center CAP Review. I have reviewed each recommendation and concur with the findings.

2. If you have any questions or wish to discuss this report, please contact me at (313) 576-1212.

Pamela J. Reeves, MD,

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 processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings.

Concur

Target date for completion: June 20, 2015

Facility response: Anesthesia Service has assigned two staff members, a primary and alternate member, to the Blood Usage Review Committee. The Chair of the Committee will contact both Anesthesia Service members by email prior to the scheduled meetings which are held every other month. If the Anesthesia Service members do not respond, the committee chair will contact the members by phone and escalate the email notification simultaneously to the Chief of Anesthesia, Chief of Surgery and Chief of Staff. Six months of meetings will be monitored from 8-15-14 to 6-20-15. Each meeting will have minutes with an attached attendance sheet. Minutes are reviewed quarterly in the Quality Leadership Committee.

Recommendation 2. We recommended that processes be strengthened to ensure that medication carts are secured at all times and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The medication cart on the locked Psychiatric Unit required a battery which was replaced on 7-18-14 and all drawers are now able to lock. The medication cart on the acute surgical floor was repaired by replacing a latch on 8-12-14. The medication cart drawers in the Community Living Center (CLC) were left open by the nurse and the CNM has reviewed medication safety with the staff. The CNMs will randomly check the medication carts four times a month for six months for a target of 100% and report to the Nursing Performance Improvement (PI) committee and Quality and Performance (QP).

Recommendation 3. We recommended that processes be strengthened to ensure that auditory privacy is maintained in all intake areas, that managers stress to staff that sensitive patient information should not be discussed in public areas, and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response:

1. Construction for redesigning the Emergency Department is planned and will expand the number of rooms. ED staff members were educated on how to maintain privacy in limited spaces including the use of screens when the need for additional space is required. This area will be monitored randomly for a minimum of 15 observations for two quarters using the 'secret shopper' technique. The Associate Chief Nursing Service (ACNS) of Integrated Clinical Services will report the results of the observation to the Nursing Performance Improvement (PI) committee and Quality and Performance (QP). The target is 100%.

2. We will verify that residents rotating at the VA have completed the HIPPA Privacy Rules through Talent Management System (TMS). This will be completed monthly and reported to Quality and Performance (QP). In addition, it will also be added to the curriculum at the monthly medicine resident's orientation for added emphasis.

3. Signage for acknowledging the patient's privacy will be developed and posted in rooms specifically reserved for Medical and Surgical Residents. The Administrative Officer (AO) to Medicine Service will submit the requests and report completion to QP.

Recommendation 4. We recommended that processes be strengthened to ensure that all designated eye clinic employees receive eye laser safety training with the frequency required by local policy and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response:

1. Surgical Service and the Medical Staff Coordinator will ensure new users have computer and hands-on training prior to being approved to use the Laser. The physicians will provide the Medical Staff Coordinator proof of Laser training as part of the re-credentialing process every two years. Laser training compliance is monitored by the Chief of Surgical Service and reported to the Clinical Exec Committee and QP for a target of 100% compliance.

2. The medical center Laser safety policy will be revised to reflect the training requirements.

3. Physicians and OR staff that are involved with Laser procedures will take the training this year to establish a known frequency. Computer based training will be assigned on a two year cycle.

4. All OR staff members will take annual hands-on Laser competency training and document training in the Talent Management System (TMS).

Recommendation 5. We recommended that processes be strengthened to ensure that clinicians document patient/caregiver understanding of discharge instructions and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: Clinical Nurse Manager (CNM), Associate Chief Nursing Service (ACNS) for Medicine Service and QM Coordinator for Medicine Service will revise the Outpatient Discharge Handoff Template to include the statement "the patient verbalized understanding of discharge instruction "yes or no" and if no why and what is the intervention. This is a forced field and must be completed. The medical records will be audited for six months for a target of 100% and reported to the Nursing PI committee and QP. D= # of medical records; N= # of records with understanding of education documented.

Recommendation 6. We recommended that processes be strengthened to ensure that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: In 2013, NIH Stroke Scale documentation was requested to be completed by the ED providers and was not completed on all patients. The new process is the Neurology attending physicians and/or resident are responsible for completing the NIH documentation. The Chief of Neurology will monitor compliance monthly for a target of 100% and report compliance to the Clinical Executive and Quality Leadership Committees.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians screen patients for difficulty swallowing prior to oral intake.

Concur

Target date for completion: February 2, 2015

Facility response: Nursing swallow assessment protocol will integrate stroke dysphagia screen and follow up. The Stroke team will:

1. Align stroke swallow screen protocol with medical center policy, Management of Patients with Swallowing (Dysphagia) or Feeding Disorders (VHA Directive 2006-032) and obtain administrative approval.

2. Revise and assign CPRS Dysphagia Screening template as required on nursing admission for acute and LTC, consistent with new policy.

3. Develop and implement training program for all applicable nursing staff re: swallow screen procedure and follow-up on admission and for other specified indications.

4. Assign and monitor monthly training completion in TMS over six months and report to Quality and Performance and the Stroke Steering Committee. The Stroke Center Director (also the Chief of Neurology) will monitor compliance with swallow screen for all acute stroke admissions through monthly VISN 11 Data Warehouse report (Stroke Steering Committee). The target is 100%.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians provide printed stroke education to patients upon discharge and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: Stroke education has been embedded into the Physician discharge note. Physicians will be responsible for checking the stroke education button for every stroke patient for review and understanding. When the discharge note is printed, the stroke education is included. A random audit of 50% of acute stroke patients will be completed monthly by the ACNS for Integrated Clinical Service (ICS) and Medicine Service for 6 months. The target is 100%.

Recommendation 9. We recommended that processes be strengthened to ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The Stroke Center Director will ensure Integrated Clinical Services providers complete required training and document in TMS. Training will be required every two years. The Stroke Center Director will monitor compliance quarterly, including training for new staff members and, report to the Clinical Executive and Quality Leadership Committees. The target is 100%.

Recommendation 10. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The Restorative Coordinator will develop a weekly documentation note that addresses restorative orders per clinician orders and/or resident care plan, revise audit tool to capture restorative requirements and educate staff on revised weekly note. The Restorative Coordinator will document training in Talent Management System (TMS). The Community Living Center (CLC), Clinical Nurse Managers (CNMs) will monitor and compliance weekly and report compliance monthly to Nursing Performance Improvement (PI) committee and Quality and Performance (QP). Target – 100% compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that staff modify restorative nursing interventions as needed and document the modifications and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The weekly note will include resident progress towards goals or consult to Restorative Coordinator if compliance is not met or if modifications to the plan need to be addressed. The CLC CNMs will complete a weekly audit of documentation in the weekly note and report compliance monthly to Nursing PI committee and QP. Target – 100% compliance.

Recommendation 12. We recommended that processes be strengthened to ensure that staff document the reasons for not providing restorative nursing services when those services are care planned and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The Restorative Coordinator will reinforce education on documentation requirements of daily restorative services. The CNMs will monitor documentation weekly and report compliance monthly to Nursing PI committee and QP. Target – 100% compliance.

Recommendation 13. We recommended that processes be strengthened to ensure that hand-off communication occurs between Physical Medicine and Rehabilitation Service and the community living center when residents are discharged from therapy to ensure that restorative nursing services occur.

Concur

Target date for completion: February 2, 2015

Facility response: The Chief of PM&R and ACNS for Geriatrics will ensure hand-off communication occurs between PM&R and CLC when residents are discharged. PM&R Chief will review Restorative Template to ensure all restorative programs are listed and that staff members use the Restorative Consult as a means of Hand-Off. 100% of residents discharged from PM&R will have a Restorative Consult.

Recommendation 14. We recommended that processes be strengthened to ensure that employees who perform restorative nursing services receive training on range of motion and resident transfers.

Concur

Target date for completion: February 2, 2015

Facility response: The Restorative Coordinator will ensure that all training activities provided to staff are addressed in the training module and documented including range of motion and resident transfers. The CNMs will monitor training and report compliance monthly to Nursing PI committee and QP for six months. Target – 100% staff training.

Recommendation 15. We recommended that processes be strengthened to ensure that staff document residents' restorative progress weekly and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: The CLC CNMs will observe for compliance to staff documentation on restorative progress during daily GEMBA walks (the process of walking around the work area to identify improvement opportunities and wasteful activities). The Restorative Coordinator will perform bi-monthly audits of documentation requirements. CNMs will monitor compliance and report monthly to Nursing PI committee and QP for six months. Target – 100% staff training.

Recommendation 16. We recommended that processes be strengthened to ensure that initial patient safety screenings are conducted and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: Providers will be instructed via email and staff meeting to order MRI exams using the MRI Procedure tab which has the pre-screening form attached to the order. Radiology will monitor and report compliance to the appropriate Service/Section Chiefs. Compliance will be monitored for six months by the Chief Technologist. Results of the monitor will be reported by the Chief Technologist at the monthly staff meeting and to QP. The target is 100%.

Recommendation 17. We recommended that processes be strengthened to ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: Revise the second screening form that is completed by the patient on the day of the procedure, to include comment/assessment for contraindications to MRI's. Screening form will be scanned into CPRS and linked to the MRI order. Radiology note will be placed in CPRS to document contraindications. Chief Technologist and or designated radiologist will monitor compliance for six months and report results at the monthly staff meeting and to QP. The target is 100%.

Recommendation 18. We recommended that processes be strengthened to ensure that all designated Level 1 ancillary staff and Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response:

1. Chief, Education and Information and the Chief Technologist identified Level 2 MRI safety training; however, the request was blocked due to access being denied by the website. We have submitted Form VA0882 on 8-12-14 to the VA Network Security Operations Center (VA-NSOC) to unblock this course. We are currently reviewing other suitable training that can be assigned to the appropriate staff if the first choice is denied. The Chief Technologist will assign annual training to the Radiology staff, monitor compliance in TMS and report results at the monthly staff meeting and to QP. The target is 100%.

2. The ACNS for Integrated Clinical Services will assign training to the appropriate nursing staff for Levels 1 and 2 training (Level 2 training for nursing staff assigned to Radiology), monitor in TMS for annual training and report compliance in Nursing PI committee and to QP.

Recommendation 19. We recommended that processes be strengthened to ensure that two-way communication devices are regularly tested and that compliance be monitored.

Concur

Target date for completion: February 2, 2015

Facility response: On 7-22-14, the Chief Technologist updated the daily QA log record to include documentation of daily testing of the communication device on the GE scanner. The QA log record will be initiated for the Phillips scanner. All MRI technologists were notified to document testing. Compliance monitoring will be done by the Chief Technologist, reported at the monthly staff meeting and to QP. The target is 100%.

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Endnotes

[a] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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[c] References used for this topic included:
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[e] The references used for this topic were:
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