Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02716-42

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

December 8, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CPR	cardiopulmonary resuscitation
EN	enteral nutrition
EOC	environment of care
facility	Robert J. Dole VA Medical Center
FY	fiscal year
IC	infection control
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, KS

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 12, 2011.

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

- Coordination of Care
- Management of Workplace Violence
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishments were improved chronic pain management and a commitment to address employees' concerns.

Recommendations: We made recommendations in the following four activities:

Quality Management: Re-evaluate patients immediately prior to administration of moderate sedation, and document the assessment.

Environment of Care: Ensure designated staff complete laser safety training and annual N95 respirator fit testing, and monitor compliance. Keep linen, equipment storage, and supply rooms clean and properly maintained. Ensure that containers for contaminated sharps are maintained upright throughout use and that emergency supplies on crash carts are not outdated.

Enteral Nutrition Safety: Revise enteral nutrition and infection control policies, and monitor compliance with the updated policies. Ensure enteral nutrition documentation includes all required elements.

Registered Nurse Competencies: Complete competency validation documentation.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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 administration and QM.
- 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

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through September 16, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Robert J. Dole VA*

Medical Center, Wichita, Kansas, Report No. 08-02414-82, March 3, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 56 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.

Reported Accomplishments

Improved Chronic Pain Management

In January 2011, the facility implemented the Pain Management Board that meets monthly to review patients suffering from chronic pain that is not relieved by traditional approaches. At each meeting, a forum of various specialists reviews three or four of the most complex patients and recommends a pain management plan. The board meetings are open to all clinical staff and serve as an excellent educational tool that is approved for continuous medical education hours. Medical record reviews confirm that pain management has improved for patients presented to the board.

Commitment to Address Employees' Concerns

In response to employee satisfaction scores from the All Employee Survey, the facility implemented a website where employees can post anonymous questions to the facility's Director. Content experts research the questions, and the Director posts answers for all employees to view. In 3 months, 115 questions have been asked and answered. The average turnaround time is 72 hours with many questions answered within 24 hours.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant

documents. We identified the following area that needed improvement.

Moderate Sedation. Facility policy requires that physicians re-evaluate patients immediately prior to the administration of moderate sedation. We reviewed the medical records of 10 patients who had selected procedures where moderate sedation was used and found that physicians did not re-evaluate 7 patients immediately prior to administration of sedation.

Recommendation

1. We recommended that processes be strengthened to ensure that physicians re-evaluate patients immediately prior to moderate sedation and that the assessment is documented.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected inpatient units (medical/surgical, intensive care, and community living center), the emergency department, the same day surgery/post-anesthesia care unit, and outpatient clinics. The environment was generally clean and safe in patient and public areas. However, we identified the following conditions that needed improvement.

IC. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 25 employee training records and determined that 7 designated employees did not have the required annual fit testing.

The Joint Commission requires the facility to maintain a safe environment and reduce the risk of infections. In five of the six clinical areas inspected, we found multiple linen, equipment storage, and supply rooms that were dirty and unkempt.

Sharps Containers. The Occupational Safety and Health Administration requires that containers for contaminated sharps be maintained upright throughout use. In two clinical areas, we found multiple sharps containers that could easily be tipped over and cause spillage of contaminated sharps because they were not secured.

Laser Safety Training. Facility policy requires that all laser users be trained on the proper use of such equipment. None of the three designated staff had completed laser safety training.

Crash Carts. Facility policy requires staff to check crash carts monthly for any outdated emergency supplies. Four of the 12 crash carts we inspected had expired emergency supplies.

Recommendations

2. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

3. We recommended that processes be strengthened to ensure that linen, equipment storage, and supply rooms are clean and properly maintained.

4. We recommended that processes be strengthened to ensure that containers for contaminated sharps are maintained upright throughout use.

5. We recommended that designated staff complete laser safety training and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that crash carts do not have outdated emergency supplies.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following areas that needed improvement.

Policy. VHA requires that health care staff follow specific procedures related to EN.[1] Facility EN policy had not been updated to be consistent with current VHA policy. For example, facility policy did not require x-ray verification of tube placement prior to using the tube for EN feedings.

[1] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

VHA also requires that facility IC policy address EN.[2] We reviewed facility IC policy and determined that it did not address IC expectations for EN, such as swabbing the tops of EN cans with alcohol wipes before pouring contents into feeding bags.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[3] We reviewed the medical records of 10 EN patients and found that 8 records did not contain all required information, such as x-ray verification of nasogastric tube placement prior to use for EN feedings and checking gastric residual.

Recommendations

7. We recommended that facility policy related to EN be updated to be consistent with VHA policy, that facility IC policy be revised to include EN IC expectations, and that compliance with the updated policies be monitored.

8. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to perform their responsibilities. Core competencies, such as medication administration, are skills required for all RNs. Position competencies are specific to a particular area of patient care, such as an intensive care unit. Six of the 12 RN competency folders had incomplete or missing validation documentation.

Recommendation

9. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

[2] VHA Handbook 1109.05.
[3] VHA Handbook 1109.05.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed patients' medical records and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 15–20 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[4]		
Type of Organization	General medical and surgical facility	
Complexity Level	2	
VISN	15	
Community Based Outpatient Clinics	Fort Dodge, KS Hays, KS Hutchinson, KS Liberal, KS Parsons, KS Salina, KS	
Veteran Population in Catchment Area	Projected population – 96,288 Projected enrollees – 35,037	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	41	
• **Community Living Center/Nursing Home Care Unit**	40	
• **Observation Beds**	6 surgical/6 medical = 12 total	
Medical School Affiliation(s)	Kansas University School of Medicine – Wichita	
• **Number of Residents**	10	
	FY 2011 (through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$161	$166
• **Medical Care Expenditures**	$86	$165
Total Medical Care Full-Time Employee Equivalents	929	881
Workload:		
• **Number of Station Level Unique Patients**	24,885	28,010
• **Inpatient Days of Care:**		
o **Acute Care**	4,487	9,186
o **Community Living Center/Nursing Home Care Unit**	6,647	13,622
Hospital Discharges	941	2,071
Total Average Daily Census (including all bed types)	60.1	62.7
Cumulative Occupancy Rate (in percent)	Hospital – 60.3 Community Living Center – 88.6	Hospital – 61.9 Community Living Center – 93.3
Outpatient Visits	133,897	255,899

[4] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure all facility employees who require CPR and automated external defibrillator training have current certification.	Education developed a tracking system for all staff who require CPR and automated external defibrillator training. Staff and supervisors are advised prior to expiration dates, and if training is not completed, staff are removed from patient care areas until completion. Reports go to the Quality Performance Council.	Y	N
2. Modify the local CPR policy to include all employees who require training and to define the process for tracking current training.	The Code Blue policy was updated. A recent update refines and defines staff and the requirement for CPR, automated external defibrillator, and Advanced Cardiac Life Support training. Reports go to the Quality Performance Council.	Y	N
EOC			
3. Maintain medication refrigerator cleanliness in accordance with local policy.	Refrigerator cleaning is monitored through EOC rounds or tracers.	Y	N
4. Revise the local hand hygiene policy to include a requirement to monitor health care workers' adherence to hand hygiene practices and provide health care workers with information regarding their performance.	Local policy was revised, and staff are provided information through service line meetings. Postings are in various places in the service areas. IC staff visit with veterans about staff washing their hands. Hand hygiene monitors are completed and submitted to the Quality Performance Council.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Ensure that staff are aware of the procedures to follow in the event of a hazardous spill.	Annual EOC education includes this, and additional information was provided to supervisors to share with staff. Education sends reminders to staff and supervisors at 90, 60, and 30 days. Education runs Compliance Deficiency Reports and sends reminders to the appropriate areas.	Y	N
6. Monitor and test the electronic elopement system according to the manufacturer's recommendations.	Bio-med completes checks twice a year. Monitors are in place in the areas that have the system and are kept in a binder. EOC rounds and tracers are used to monitor compliance with staff completing checks.	Y	N
7. Ensure staff use electrical appliances safely.	Annual EOC education includes this, and additional information was provided to supervisors to share with staff. Education sends reminders to staff and supervisors at 90, 60, and 30 days. Education runs Compliance Deficiency Reports and sends reminders to the appropriate areas.	Y	N
Coordination of Care			
8. Consistently complete intra-facility transfer documentation, as required by local policy.	Transfer/hand-off templates were implemented. Re-education is ongoing among staff nurses in some areas after completion of monitoring tool. Reports continue to the Quality Performance Council.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
9. Consistently complete discharge documentation, as required by Joint Commission standards and local policy.	Discharge documentation has been monitored by staff nurses who have assisted others in the entire discharge process. Reports to the Quality Performance Council show 100 percent compliance.	Y	N
Emergency/Urgent Care Operations			
10. Complete inter-facility transfer documentation, as required by VHA and local policy.	Teams/workgroups continue to strive to have more complete documentation through refinement of the templates used. Education to providers and staff about the documentation required is ongoing. Nursing is awaiting implementation of the new VA Nursing Outcomes Database charting. Reports continue to the Quality Performance Council.	Y	N
Medication Management			
11. Consistently document the effectiveness of all pain medications within the required timeframe of the local policy.	Documentation requirements for pain medication effectiveness had recently changed to 2 hours prior to the last OIG survey. Staff have been educated and re-educated regarding the 2-hour documentation requirement. Some areas have champions to assist staff with the process. Continued efforts are in place to improve in this area. Reports are sent to the Quality Performance Council.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
Pharmacy Operations			
12. Initiate and sign appointment letters for the alternate controlled substance coordinator and controlled substances inspectors.	Letters were changed and resent at the end of the last OIG survey.	Y	N

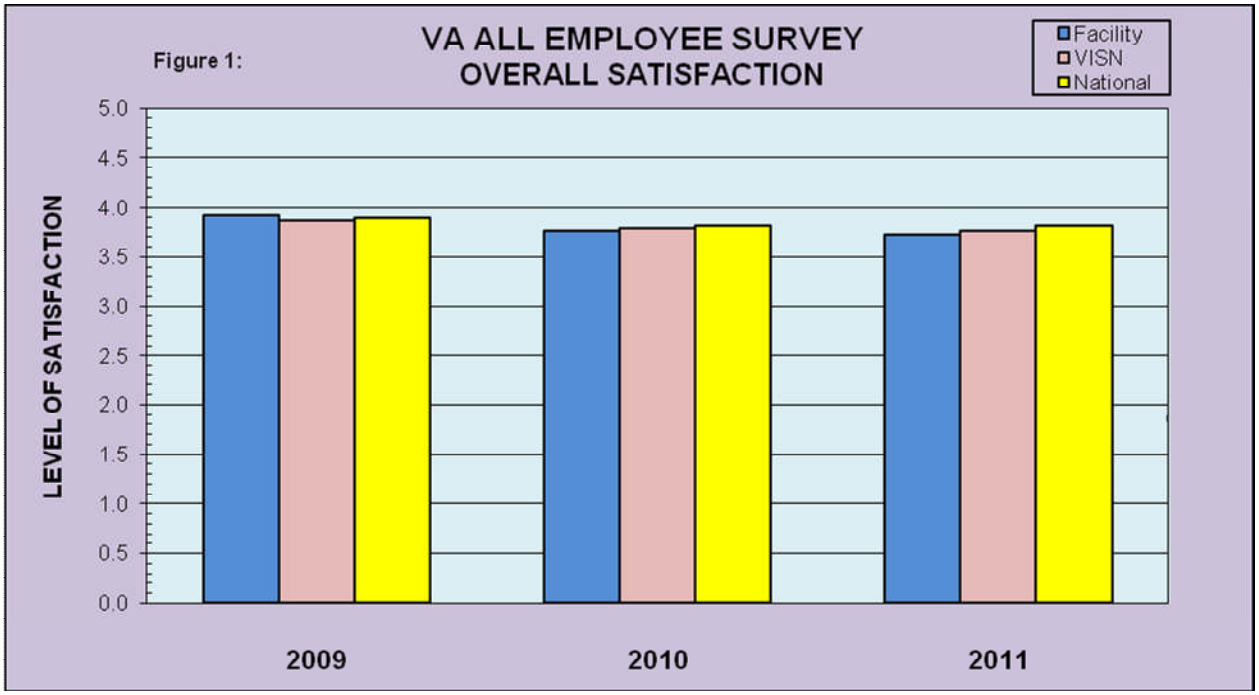
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	52.4	51.1	57.3	58.3	54.2	53.1
VISN	56.1	51.6	52.5	58.8	54.4	53.8
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[5] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[6]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	15.2	11.7	13.4	20.1	22.7	19.1
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[5] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[6] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 15, 2011

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Robert J. Dole VA Medical Center, Wichita, KS**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. Attached is the Robert J. Dole VA Medical Center, Wichita, KS response to the September CAP Draft Report. I have reviewed the report and concur with the responses.

2. If you have any questions regarding the report, contact Julie Madere, HSS at 816-701-3014.

for James Floyd, FACHE
Network Director VISN 15

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 15, 2011

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

Subject: **CAP Review of the Robert J. Dole VA Medical Center, Wichita, KS**

To: Director, VA Heartland Network (10N15)

I concur with all recommendations. Action plans are attached.

Thank you.

Tom Sanders, FACHE
Robert J. Dole VA Medical Center Director

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 processes be strengthened to ensure that physicians re-evaluate patients immediately prior to moderate sedation and that the assessment is documented.

Concur

Target Date for Completion: January 31, 2012

The current Moderate Sedation policy states "a re-evaluation just prior to the administration of sedation to determine if this anesthesia is still appropriate." The method of documentation for this will be determined by each Service Line involved. The Service Line will develop their plan and provide education to the key stakeholders. A chart review process to assure compliance will be determined by each Service Line and the report will be sent to Clinical Practice Council. This item will be on the November Clinical Practice Council agenda for further discussion and action as required.

Recommendation 2. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target Date for Completion: March 31, 2012

The current plan regarding N95 respirator fit testing was re-evaluated and it was determined that 310 employees are required to be fit tested. Classes were started in October and November of 2011 with 74 staff completing. Two more days, November 21st and December 16th are planned for N95 fit testing. More testing days will be scheduled in early 2012 for planned compliance by March 2012.

Recommendation 3. We recommended that processes be strengthened to ensure that linen, equipment storage, and supply rooms are clean and properly maintained.

Concur

Target Date for Completion: December 31, 2011

Staffing levels and requirements have been reviewed for vacancies and possible duty adjustments. Cleaning routines have been reviewed with Environmental Management Service staff. Documentation of completed routine cleaning has been implemented. Verification of cleaning routine compliance is being monitored daily by the

Environmental Management Director. Quarterly reports will be sent to the Environment of Care Committee with the first report due to the Committee in December.

Recommendation 4. We recommended that processes be strengthened to ensure that containers for contaminated sharps are maintained upright throughout use.

Concur

Target Date for Completion: January 31, 2012

Clinical areas are being evaluated for types of appropriate sharps containers. Adjustments have been made in some areas to stabilize the containers. Due to the fact there is a new mandatory contract change planned for January 2012 for sharps containers, Logistics has contacted the company for information on the new sharps containers for the subcommittee of the Commodity Standards Committee in order to be able to better evaluate all the options available for the appropriate container for a clinical area. The subcommittee will make recommendations based on regulatory requirements and the clinical area. Appropriate sharps containers will then be placed throughout the facility. Staff on the Environmental of Care rounds will monitor for compliance.

Recommendation 5. We recommended that designated staff complete laser safety training and that compliance be monitored.

Concur

Target Date for Completion: Completed

The designated staff has been identified and has completed the module in Talent Management System (TMS). Reminders are set up in TMS to ensure that they repeat the training at the next required interval. Education is monitoring.

Recommendation 6. We recommended that processes be strengthened to ensure that crash carts do not have outdated emergency supplies.

Concur

Target Date for Completion: January 31, 2012

The Critical Care Committee has been tasked with the evaluation of the entire cleaning and restocking process of the crash carts. Processes have been gathered from the VISN for review at the next Critical Care Committee meeting scheduled for November to evaluate the information as it applies to our facility. All disciplines involved have been requested for input into their portion of the process in order to update the Center Circular. Logistics staff has completed an education/re-education on the current process of checking and restocking of their portion of the crash cart. Involved disciplines will educate/re-educate their staff upon completion of the update and/or addendum to the Code Blue Center Circular. Validation of process will occur by Service

Lines involved. Reports will be sent to Quality Performance Council and Clinical Practice Council.

Recommendation 7. We recommended that the facility policy related to EN be updated to be consistent with VHA policy, that facility IC policy be revised to include EN IC expectations, and that compliance with the updated policies be monitored.

Concur

Target Date for Completion: March 31, 2012

A Rapid Improvement Team was chartered with all the involved disciplines and the Clinical Nutrition Management Supervisory Dietitian as Team Leader in October 2011. The team is utilizing VHA directives, CAP Review Guide for Enteral Nutrition Safety, and the current Center Circular to assist them. The Infection Control Practitioner is an active member of the team. The team is scheduled to meet throughout November and December 2011. The facility Enteral Nutrition Center Circular is currently being reviewed by each discipline to incorporate their service line into the circular. The completion of the circular revision is planned for December 22, 2011. It will then be sent to Clinical Practice Council for approval in January 2012. The Clinical Nutrition Management Supervisory Dietitian will assure that compliance data is reported to the Clinical Practice Council.

Recommendation 8. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Concur

Target Date for Completion: March 31, 2012

The Enteral Nutrition Team will also complete an order set and/or template to be developed in accordance with the VHA directive, CAP Review Guide and revised Center Circular. Education will then be provided to the disciplines involved in enteral nutrition. Reports of completed education of the Service Lines involved will be sent to the Quality Performance Council.

Recommendation 9. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

Concur

Target date for completion: March 31, 2012

The ICU Nurse Manager is providing documentation that ICU is in compliance with hospital policy which is due December 15th. The Nurse Education/Staff Development Committee is revising the nursing attachments to reflect that competency is demonstrated/observed and will provide those to Nursing Managers as soon as they are developed. Education will continue quarterly monitors and provide feedback to

managers. Reports will be documented in the Workforce Development Committee and Nursing Practice Council.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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