Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-04568-148

Combined Assessment Program Review of the VA Eastern Kansas Health Care System Topeka, Kansas

April 10, 2012

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

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EOC	environment of care
facility	VA Eastern Kansas Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RRTP	residential rehabilitation treatment program
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Topeka, 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 January 23, 2012.

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

- Moderate Sedation
- Psychosocial Rehabilitation and Recovery Centers
- Quality Management

The facility's reported accomplishments were implementation of an electronic tool for hazardous material inventory and a Psychosocial Rehabilitation and Recovery Center that surpassed requirements and has a graduation rate above the national average.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Perform checks of and maintenance on the community living centers' elopement prevention systems. Conduct and document safety inspections on ceiling lifts. Develop and implement a residential animal program policy. List duplicate paper records on the master inventory. Update the Mental Health Residential Rehabilitation Treatment Program policy to safely manage medications, and ensure self-inspection documentation includes all required elements.

Colorectal Cancer Screening: Notify patients of positive screening results, and document notification. Improve diagnostic testing timeliness and follow-up in response to positive screening. Notify patients of biopsy results, and document notification.

Coordination of Care: Ensure that medications ordered at discharge match those on discharge documentation, that follow-up appointments are scheduled within the timeframes requested by providers, and that providers document care hand-off.

Medication Management: Ensure clinicians screen patients for vaccinations, administer vaccinations, and document all required elements.

Polytrauma: Ensure patients with positive traumatic brain injury screening results receive comprehensive evaluations as outlined in policy.

Comments

The Acting 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
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through January 27, 2012, 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 VA Eastern Kansas Health Care System, Topeka, Kansas,* Report No. 09-03742-73, January 25, 2010). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 94 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 336 responded. Survey results were shared 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.

Reported Accomplishments

Enterprise Environmental, Safety, and Occupational Health

The facility implemented Enterprise Environmental, Safety, and Occupational Health, an electronic tool for comprehensive hazardous materials and waste management inventory. The tool enhances staff and patient safety and minimizes environmental exposures by tracking hazardous material use and reducing waste and costs. It generates a bar code for each item, thereby increasing accountability with chemical tracking from purchase to final destruction.

PRRC

The PRRC is a program based on teaching recovery oriented skills and community integration. Several components of the facility's program surpassed VHA requirements. Alumni veterans from the facility's program have returned to teach art classes and serve in structured community volunteer work at a local food bank. Veterans are also involved in program decisions, such as decorating the program space. Additionally, a vocational rehabilitation counselor is a member of the program staff and assists veterans with learning employment skills. The program's graduation rate is above the national average, and the facility Director attends each graduation ceremony and awards veterans their diplomas.

Results

Review Activities With Recommendations

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 and whether the facility's Domiciliary Care for Homeless Veterans Program was in compliance with selected MH RRTP requirements.

We inspected inpatient units (medical/surgical, intensive/progressive care, MH, and CLC), outpatient clinics (dental, primary care, and specialty care), the emergency departments, the operating rooms, and the Domiciliary Care for Homeless Veterans Program. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
X	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
X	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Patient Safety. VHA requires that CLC elopement prevention systems have a basic check every 24 hours and that preventive maintenance is performed on the systems annually.[1] The basic checks of the Topeka CLCs' elopement prevention systems were

[1] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 3, 2010.

not consistently completed, and annual preventive maintenance was not performed on the Leavenworth CLC's elopement prevention system.

VA requires that an inspection of each ceiling lift in the CLC is completed after installation and documented on the After Installation Checklist.[2] We requested inspection documentation for 20 CLC ceiling lifts. There was no documentation for six of the lifts.

Infection Prevention. VHA requires that the facility develop and implement a local policy if they have a residential animal program.[3] The CLCs had a residential animal program; however, the facility had not developed and implemented a policy.

Dental Record Inventory and Storage. Local policy requires that an accurate inventory of records be created and stored by individual services and that a master inventory of records be maintained. We found hundreds of duplicate paper dental records stored in the Leavenworth dental clinic that had not been reported and listed on the master inventory of records. No one could explain why the paper records were necessary since the information was in the electronic health record.

MH RRTP Policy. VHA requires that MH RRTP managers develop a policy to safely manage medications that includes specific elements.[4] We found that the local medication policy for the Domiciliary Care for Homeless Veterans Program had not been updated to include all VHA requirements.

MH RRTP Inspections. VHA requires that facilities conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy.[5] Although monthly self-inspections had been completed for the past 6 months, documentation did not consistently include all required elements.

Recommendations

1. We recommended that processes be strengthened to ensure that basic checks of the Topeka CLCs' elopement prevention systems are consistently completed every 24 hours and that annual preventive maintenance is performed on the Leavenworth CLC's elopement prevention system.

2. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the CLCs and documented.

3. We recommended that a policy be developed and implemented for the CLCs' residential animal program.

[2] VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
[3] Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
[4] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[5] VHA Handbook 1162.02.

4. We recommended that duplicate paper dental records in the Leavenworth dental clinic be removed or reported and listed on the master inventory of records.

5. We recommended that MH RRTP managers update the policy to safely manage medications to include all VHA requirements and monitor compliance with the updated policy.

6. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspection documentation includes all required elements.

CRC Screening

The purpose of this review was to follow up on the report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[6] Five patients' records did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[7] Five patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[8] Three of the 15 patients who received diagnostic testing did not receive that testing within the required timeframe.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that

[6] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[7] VHA Directive 2007-004.
[8] VHA Directive 2007-004.

clinicians document notification.[9] Of the 11 patients who had a biopsy, 3 records did not contain documented evidence of timely notification.

Recommendations

7. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

8. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

9. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

10. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[9] VHA Directive 2007-004.

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 29 HF patients' medical records and relevant facility policies, and we interviewed employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
X	The facility complied with any additional elements required by local policy.

Discharge Medications. The Joint Commission's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In three records, medications ordered at discharge did not match those listed in the discharge summary, physician discharge, or pharmacy discharge counseling notes.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[10] Although provider discharge instructions requested specific follow-up appointment timeframes, 15 appointments were not scheduled as requested.

Hand-Off Communication. Local policy requires that inpatient providers document care hand-off to outpatient providers before patients are discharged. Nineteen records did not include documentation of hand-off communication.

Recommendations

11. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed in the discharge summary, physician discharge, or pharmacy discharge counseling notes.

12. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

13. We recommended that processes be strengthened to ensure that providers document care hand-off in accordance with local policy.

[10] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff screened patients for pneumococcal and tetanus vaccinations.
X	Staff properly administered pneumococcal and tetanus vaccinations.
X	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Seven (23 percent) records lacked documentation of vaccination screening.

Vaccination Administration. The Centers for Disease Control and Prevention recommends that when indicated, clinicians administer tetanus vaccinations. Seven patients who met criteria for vaccination were not vaccinated. None of those patients' records contained documentation regarding vaccinations.

Vaccination Documentation. Federal law requires that documentation for administered vaccinations include specific elements, such as the vaccine information statements. Clinicians did not document all required elements in the records of the three patients who received vaccinations.

Recommendations

14. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

15. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

16. We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive TBI results, and training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[11] A higher level Polytrauma System of Care site must complete the comprehensive evaluation or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

We reviewed the medical records of 10 patients who screened positive for TBI. One patient refused further evaluation, and another patient had been evaluated previously. The remaining eight patients received the comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. Additionally, the

[11] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation.

Recommendation

17. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Review Activities Without Recommendations

Moderate Sedation

The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, six medical records, and training/competency records, and we interviewed key individuals. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that 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 complied with any additional elements required by local policy.

Comments

The Acting VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 23–30, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[12]		
Type of Organization	Two divisions—Leavenworth and Topeka. Provide primary and secondary care in medicine and surgery and tertiary care in psychiatry.	
Complexity Level	2	
VISN	15	
Community Based Outpatient Clinics	Chanute, KS Emporia, KS Fort Scott, KS Garnett, KS Junction City, KS Wyandotte, KS Lawrence, KS Seneca, KS St. Joseph, MO	
Veteran Population in Catchment Area	100,000+	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	238	
• **CLC/Nursing Home Care Unit**	138	
• **Other**	202 domiciliary	
Medical School Affiliation(s)	University of Kansas University of Missouri	
• **Number of Residents**	151	
	Current FY (through December 2011)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$214	$242
• **Medical Care Expenditures**	$63.4	$242
Total Medical Care Full-Time Employee Equivalents	1,728	1,745
Workload:		
• **Number of Station Level Unique Patients**	25,614	37,020
• **Inpatient Days of Care:**		
o **Acute Care**	5,787	41,074
o **CLC/Nursing Home Care Unit**	6,872	93,869
Hospital Discharges	1,547	5,734
Total Average Daily Census (including all bed types)	391.2	369.7
Cumulative Occupancy Rate (in percent)	69.45	71.51
Outpatient Visits	103,547	407,319

[12] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation?**
EOC		
1. Ensure that staff cleanse and disinfect equipment between patient uses.	Local policies and manufacturer recommendations for cleaning equipment are available on the public drive. Proper disinfecting/cleaning of reusable medical equipment is reviewed during monthly tracer activities in each clinical area. There have been no negative findings.	N
2. Ensure that staff identified as at risk for exposure to a harmful atmosphere receive respirator fit testing, training, and medical evaluation, as required.	When a new employee arrives, the supervisor identifies whether the employee needs to be fit tested. Once the employee is identified, the fit test procedure begins. Once the employee has been medically cleared, he/she schedules a time to be fit tested. If an employee has not been fit tested and needs to enter an isolation room, he/she is fit tested prior to entering the room.	N
3. Ensure that all sharps containers are mounted within the required height range.	All sharps containers were relocated to the appropriate height. Completion date was February 25, 2010.	N
Medication Management		
4. Ensure that nurses consistently assess and document as needed pain medication effectiveness within the timeframe specified by local policy.	As needed pain management effectiveness is monitored on a weekly basis.	N
5. Ensure that pharmacists consistently perform and document monthly medication reviews on the CLC units.	Monthly medication reviews have been at 100 percent compliance.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation?
Coordination of Care		
6. Ensure that staff complete discharge documentation in accordance with VHA and Joint Commission standards.	Monthly data is collected by the service lines and shared with executive leadership.	N
QM		
7. Ensure that a designated, trained physician serves as an advisor for the utilization management program, as required by VHA policy.	A designated, trained physician serves as an advisor for the utilization management program.	N
Contracted/Agency Registered Nurses		
8. Ensure that contracted/agency registered nurses have evidence of completed background investigations and clinical competence prior to providing patient care.	The facility does not have any contracted/agency registered nurses on board.	N

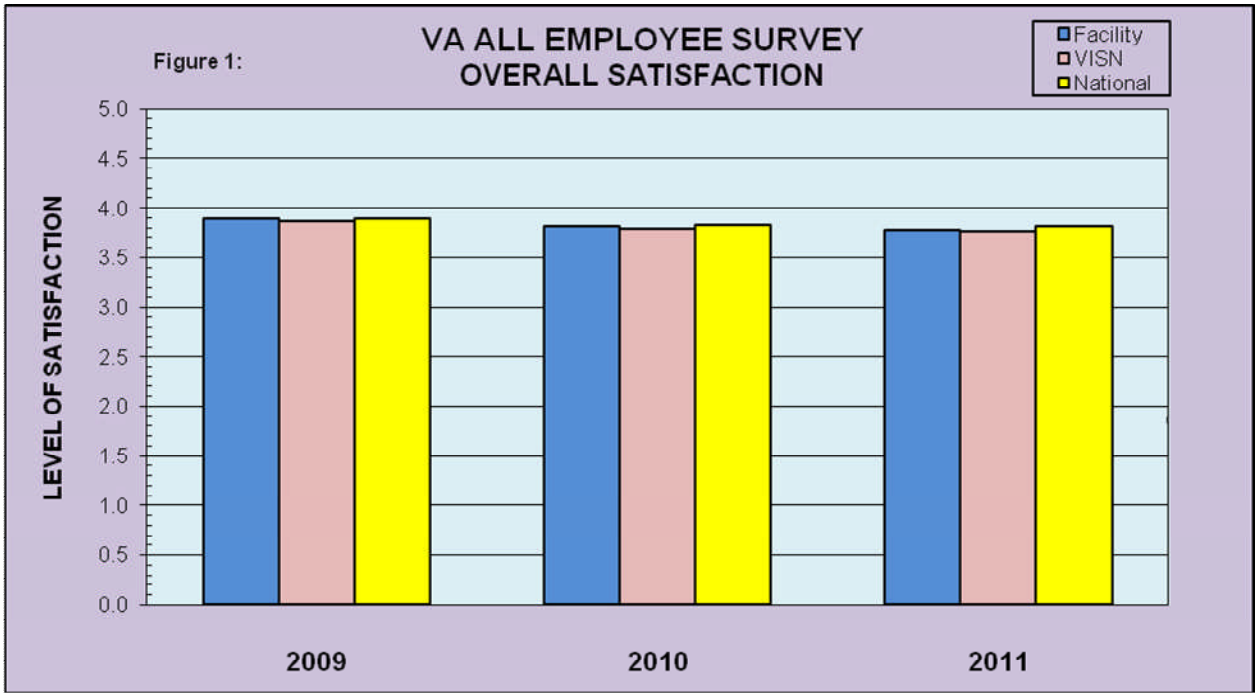
VHA Satisfaction Surveys

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 satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	62.9	64.4	55.0	54.1	55.9	50.6
VISN	58.8	57.8	54.4	53.8	52,2	51.7
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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.[13] 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.[14]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.2	11.0	11.4	21.7	27.7	17.2
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[13] 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 HF 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.

[14] 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.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 3/20/2012

From: Acting Director, VA Heartland Network (10N15)

Subject: **CAP Review of the VA Eastern Kansas Health Care System, Topeka, KS**

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

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

I have reviewed and concur with the CAP review draft report recommendations and VA Eastern Kansas Health Care System, Topeka, KS, status response(s). Thank you for this opportunity of review as a process to ensure that we continue to provide exceptional care to our Veterans.

If you have any questions regarding the information provided, please contact Mary Weier, Chief of Quality Management at 913-682-2000, ext. 52146.

/s/ signed William P. Patterson, MD, MSS

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 3/15/2012

From: Director, VA Eastern Kansas Health Care System (589A5/A6/00)

Subject: **CAP Review of the VA Eastern Kansas Health Care System, Topeka, KS**

To: Acting Director, VA Heartland Network (10N15)

I have reviewed the issues outlined in the draft report and concur with the recommendations. My response to the recommendations is attached. I appreciate the Office of Inspector General's comprehensive review and efforts to ensure high quality of care to our Veterans.

If you have any questions or require additional information, please contact Mary Weier, Chief of Quality Management at 913-682-2000 ext 52146.

/s/ signed Judy K. McKee, FACHE

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 basic checks of the Topeka CLCs' elopement prevention systems are consistently completed every 24 hours and that annual preventive maintenance is performed on the Leavenworth CLC's elopement prevention system.

Concur

Target date for completion: Implemented

Wanderguards are checked daily in conjunction with patient safety rounds. Engineering will perform monthly preventative maintenance on the equipment per manufacturer's standards.

Recommendation 2. We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the CLCs and documented.

Concur

Target date for completion: 4/30/2012

Ceiling lifts have been added to the weekly safety checks. Nursing has been educated on basic safety issues related to the ceiling lifts. They are aware of issues such as equipment not charging properly, frayed cords, and motor smelling hot. Equipment will be taken out of service per hospital policy and a work order will be placed when a variance outside of normal operation is noted. Engineering will complete monthly rounds including monthly preventative maintenance checks at all locations. A Standard Operating Procedure is being developed to set guidelines for the engineering process.

Recommendation 3. We recommended that a policy be developed and implemented for the CLCs' residential animal program.

Concur

Target date for completion: 5/30/2012

A residential animal program policy has been completed and is going through concurrence during the next review (April 25th).

Recommendation 4. We recommended that duplicate paper dental records in the Leavenworth dental clinic be removed or reported and listed on the master inventory of records.

Concur

Target date for completion: 4/30/2012

All shadow charts have been removed from the Dental area in Leavenworth and taken into Medical Records. Documents will be properly scanned into CPRS and/or destroyed to bring the clinic into compliance. The Records Manager and Privacy Officer will assist the Dental Clinic in the purging of unnecessary records in both clinics. Both clinic areas will have proper storage and maintenance of necessary patient information. Standard Operating Procedures outlining proper maintenance and disposal of patient records will be created for standardization across both divisions.

Recommendation 5. We recommended that MH RRTP managers update the policy to safely manage medications to include all VHA requirements and monitor compliance with the updated policy.

Concur

Target date for completion: 5/7/2012

The policy to safely manage medications has been updated to include all VHA requirements. A written Standard Operating Procedure will outline requirements for monitoring patient compliance.

Recommendation 6. We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspection documentation includes all required elements.

Concur

Target date for completion: 4/30/2012

Inspections are completed ensuring that privacy, security, and safety elements are included. Work orders are now printed and kept in a binder in order to be able to track completion status. The Domiciliary will track and ensure that work orders are being completed in a timely manner in collaboration with Engineering, results will be reported to the EOC Committee.

Recommendation 7. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Implemented

All positive screening tests are entered onto a GI screening spreadsheet. GI clinic administrative staff is responsible to track Veteran's with positive screening and verify that the patient record shows documentation of a positive CRC screening test notification. GI clinical staff alerts the responsible provider and the provider's nurse once the test result is 7 days old. If no action is taken, administrative staff will then notify the supervising physician to ensure the Veteran is notified of the positive screening result. Clinicians are expected to follow the facility Health System Policy Memorandum requiring notification of test results using either a clinical reminder or the Eastern Kansas Test Notification note title.

Recommendation 8. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: Implemented

GI clinic administrative staff will monitor that Veteran's with positive screening tests also have documented follow-up plans. This will be in conjunction with verification that the patient received notification of a positive screening test. Clinicians are expected to document follow-up plans in their note and immediately initiate a GI consult if that is their desired course of treatment. Veterans that do not have documented follow-up plans within 7 days of positive screening test will be alerted to the provider and the nurse. If no action is taken the provider's supervisor will then be alerted to ensure that a follow-up plan is initiated and documented.

Recommendation 9. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: Implemented

Additional clinic slots have been blocked to match the historical rate of positive screening tests requiring diagnostic testing to ensure that access to these clinics is available. Also, scheduling staff have been educated that the diagnostic testing is to be scheduled within the required 60 days of the positive screening test, not within 60 days of the date the provider initiates a consult. Schedulers have also been directed to coordinate positive screening tests with the GI Physician Assistants to accommodate overbooks if required to ensure that the diagnostic testing is completed within 60 days.

Recommendation 10. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: 4/30/2012

Both campuses are now required to utilize the Eastern Kansas Biopsy Result note template which ensures proper documentation that Veterans have been notified of biopsy results. Additionally, the GI Physician Assistants are now responsible to track that once a biopsy is taken an electronic spreadsheet is created and the Veteran is tracked to ensure that the biopsy result is given to the patient within 14 days.

Recommendation 11. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed in the discharge summary, physician discharge, or pharmacy discharge counseling notes.

Concur

Target date for completion: Implemented

Changes have been implemented to the PC discharge note so that providers are required to list out medications manually. A Pharmacist now rechecks the PC discharge note for discrepancies in the discharge medications and the discharge medication documentation. If a discrepancy is identified, the ordering provider is notified and an addendum is added to clarify the discrepancy.

Recommendation 12. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: 4/30/2012

Discharging providers now utilize approximate time frames for follow-up for patients that do not require a specific timeline for follow up with the primary care provider. If a patient does require a specific timeframe for follow-up the discharging provider will discuss with the PCP to set an appropriate follow up date. Once the Veteran is discharged, the PC Registered Nurse Care Manager will contact the Veteran within 2 days of discharge and the follow-up appointment with the PCP is scheduled by the Registered Nurse to ensure that the Veteran is seen within the appropriate timeframe. The Registered Nurse has the capability to overbook patients to ensure that follow-up timeframes are met.

Recommendation 13. We recommended that processes be strengthened to ensure that providers document care hand-off in accordance with local policy.

Concur

Target date for completion: 4/1/2012

Hospitalists will communicate discharge plans with the patient's assigned PCP by either alerting the provider when the discharge summary is complete or listing the PCP as an additional signer on the discharge summary. The decision to receive an alert or be listed as a additional signer is left to the discretion of each PCP based on patient management strategies currently being utilized by the individual Patient Aligned Care Teams.

Recommendation 14. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: Implemented

CLC Admissions – Nursing screens new admissions, with assistance from the patient and/or home caregiver, regarding the patient's tetanus immunization status. Pharmacy and Nursing reviews the patient's immunization status utilizing the reports tab in CPRS. If the patient is eligible for a tetanus vaccination, the patient's provider is notified via a progress note from Nursing, Pharmacy, and/or Minimum Data Set Coordinator. The patient's provider will order the tetanus vaccine unless there is a contraindication. This process was fully implemented in December 2011. There is also an active clinical reminder in CPRS to screen for inpatients that are eligible for a tetanus vaccination. This clinical reminder was fully activated in August 2011.

PC Clinic Visits – A clinical reminder for tetanus vaccination has been developed and activated in CPRS to allow clinicians the ability to screen for patients that are eligible for a tetanus vaccination. This CPRS clinical reminder was fully activated in August 2011. Reports will be generated utilizing this CPRS clinical reminder to track and monitor compliance with this preventive health vaccination measure.

Recommendation 15. We recommended that processes be strengthened to ensure that clinicians administer tetanus vaccinations when indicated.

Concur

Target date for completion: 4/30/2012

All Veterans are screened for tetanus vaccination appropriateness and need. The Mid-Level practitioner screens and orders the vaccination as indicated. A nursing staff member tracks and maintains a record of Veterans who have received the vaccination.

One of the quality indicators for Geriatrics and Extended Care include quarterly reviews of eligible residents who have been offered or will receive the vaccine.

Recommendation 16. We recommended that processes be strengthened to ensure that clinicians document all required vaccination administration elements and that compliance is monitored.

Concur

Target date for completion: 4/30/2012

All elements are now required documentation on a CPRS template. Compliance will be monitored by the Nurse Manager or designee on 100 percent of those vaccinated until full compliance is reached for 2 months, then audits will be at 5 charts per month of those vaccinated.

Recommendation 17. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: 5/6/2012

Eastern Kansas Health Care System has sent forth a comprehensive TBI Evaluation Alternative Plan to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA Directive 2010-012.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Dorothy Duncan, RN, MHA, Project Leader James Seitz, RN, MBA, Team Leader Karen McGoff-Yost, LCSW, MSW Larry Selzler, MSPT Jennifer Whitehead, Program Support Assistant Greg Billingsley, Office of Investigations

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