



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-00903-422

Healthcare Inspection

Quality of Care Issues
Sheridan VA Healthcare System
Sheridan, WY

July 14, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to review allegations about quality of care issues and denial of care/refusal to admit at the Sheridan VA Healthcare System (facility) in Sheridan, Wyoming.

We could not substantiate the allegation that the facility did not adhere to clinical care recommendations previously identified by the facility for the management of a patient's dysphagia (difficulty swallowing) during a 2013 admission. Onsite interviews and documentation in the patient's electronic health record indicated staff knowledge of the patient's risk for aspiration; however, electronic health record documentation does not provide conclusive evidence of the steps taken to manage the patient's dysphagia. In addition, we found that the facility lacked a mechanism or process that would assist staff in quickly detecting previously identified dysphagia and aspiration risk. While not an allegation, we found that the patient's respiratory distress was not adequately addressed after admission in the hours immediately prior to the patient's death.

We did not substantiate the allegation that the patient received a suprapubic catheter solely to ease the patient's care for previous caregivers.

We did not substantiate the allegation that the facility failed to adequately address the patient's care needs as an outpatient causing him to become more acutely ill before being admitted.

We did not substantiate the allegation that the facility refused to provide physical therapy for the patient.

We did not substantiate the allegation that the facility refused to receive the patient via ambulance on multiple occasions when contacted by ambulance personnel transporting the patient.

In the course of our review, we found that the facility and the Veterans Integrated Service Network (VISN) had conducted internal reviews related to the patient's death. Because the VISN report is protected under privacy laws, further discussion of the objectives, findings, and recommendations, if any, is prohibited by law.

We recommended that the Facility Director: (1) ensure that staff comply with Veterans Health Administration and facility policies and practices related to the management of dysphagia, including assessment and documentation of a patient's response to the provided care recommendations and aspiration risk precautions; (2) implement applicable recommendation(s) from previous event-related reviews, if any; and, (3) review local privileging processes to ensure compliance with local policy and Veterans Health Administration Handbook 1100.19.

Comments

The VISN and Facility Directors concurred with our findings and recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 12–15 for 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to review allegations about quality of care issues and denial of care/refusal to admit at the Sheridan VA Healthcare System (facility) in Sheridan, Wyoming. The purpose of the review was to determine whether the allegations had merit.

Background

Facility

The facility, part of Veterans Integrated Service Network (VISN) 19, is located in northeastern Wyoming and has 185 authorized beds. The facility provides psychiatric and medical care, including extended care and an urgent care clinic (UCC); it does not have an emergency department (ED) or intensive care unit (ICU). The facility operates a Domiciliary Residential Treatment Program for Homeless Veterans and five community based outpatient clinics located in Casper, Gillette, Powell, Riverton, and Rock Springs, Wyoming. Its primary catchment area extends to patients from Wyoming, Montana, Colorado, Utah, and parts of Idaho.

Allegations

The VA OIG's Hotline Division received a letter dated October 31, 2013, with the following allegations relating to a specific patient:

- During the admission in which the patient died, the facility did not adhere to clinical care recommendations previously identified by the facility for the management of the patient's dysphagia.¹
- The patient had not been diagnosed with a neurogenic bladder² and received a suprapubic catheter³ solely to ease the care on previous caregivers.
- Several times a year, the facility failed to adequately address the patient's care as an outpatient, causing him to become more acutely ill before eventually being admitted.
- The facility refused to provide physical therapy for the patient.

¹ Dysphagia is defined as difficulty in swallowing. Dysphagia occurs when the muscles and nerves that help move food through the throat and esophagus are not working properly. This can happen as a result of injuries or diseases including traumatic brain injuries.

² Neurogenic bladder is the term used when there is a problem with the nerves controlling how the bladder stores and empties urine. Some people with neurogenic bladders use a urinary catheter to drain the bladder of urine.

³ A suprapubic catheter is a tube inserted into the bladder through a small surgically-created hole in the abdomen to drain urine from the bladder.

- On multiple occasions, the facility refused to receive the patient via ambulance when contacted by ambulance personnel transporting the patient.

In the course of our review of this patient's care, we identified concerns regarding the management of the patient's respiratory distress. In response to the quality of care concerns identified in the care of this patient prior to his death, we examined the credentialing and privileging files for the providers involved with the case and the facility's and VISN's internal review process and response to this event.

Scope and Methodology

The scope of our inspection was the review of the facility's processes related to the provision of care for a single patient.

We interviewed the complainant to clarify allegations. We reviewed relevant Veterans Health Administration (VHA) and facility policies and procedures, quality management documents, the patient's VA electronic health records (EHR) and non-VA medical records, credentialing and privileging documents, and industry standards. We conducted a site visit on October 15–16, 2014. We interviewed clinical staff, VISN leadership, facility leadership, and quality management staff knowledgeable about the case and actions following an inpatient death.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was in his early sixties and had suffered a traumatic brain injury (TBI) after a motor vehicle accident almost 20 years previously. His TBI had permanently disrupted the normal functioning of his brain resulting in the limited functional use of his limbs and impaired cognition. The facility had treated the patient for more than 15 years. The patient had a history of complex medical issues including diabetes mellitus,⁴ dysarthria,⁵ and dysphagia secondary to the TBI. In addition to the TBI, the patient was diagnosed with organic brain syndrome (OBS)⁶ resulting in agitation, impulsivity, loss of memory, and the eventual loss of his independence.

Since initiating care at the VA, the patient had been hospitalized at the facility 11 times. The hospitalizations occurring over the last 2 years of his life primarily addressed respiratory problems/pneumonia. Documentation in the VA EHR revealed a number of visits to the local community hospital ED and one admission to the community hospital over the same period of time to address respiratory/pneumonia concerns. In summer 2011, the patient was evaluated by a Speech Language Pathologist and found to be at high risk for aspiration.⁷ Six months later, in an effort to address his recurrent aspiration pneumonia,⁸ the patient had a consultation with a pulmonologist. The pulmonologist indicated that should matters worsen, the only remaining treatment option would be the placement of a feeding tube. The patient's family declined, noting the importance of food to the patient.

In fall 2013, the patient was brought to a community hospital ED for severe congestion of the upper airway. His blood work was within normal limits; a chest x-ray did not show pulmonary infiltrates.⁹ However, he was hypoxic,¹⁰ with a room air oxygen saturation of 82 percent. (Oxygen saturation is an indicator of the amount of oxygen available in the blood; normal levels range from 90–100 percent. Persons with low saturation levels can experience damage to organs as well as symptoms such as shortness of breath and an altered mental status.) While at home, the patient was using oxygen as needed for shortness of breath.

⁴ Diabetes Mellitus is a disease that affects how the body uses blood glucose (commonly called blood sugar) which is an important source of energy for the cells that make up the muscles and tissues.

⁵ Dysarthria is a motor speech disorder that occurs when the muscles of the mouth, face, and respiratory system become weak, move slowly, or do not move after a brain injury. A person with dysarthria may have slurred quiet speech that is difficult to understand.

⁶ Organic Brain Syndrome is a general term used to describe decreased mental function due to medical diseases other than a psychiatric illness. Brain injury caused by trauma can be associated with organic brain syndrome.

⁷ Aspiration into a person's airway occurs when a foreign material such as solid or liquid food, vomit, or saliva is inhaled into the lungs. This may result from impairment of the gag reflex (which sometimes is a consequence of brain injury) or from a swallowing problem. Once aspiration has occurred, a person may reflexively cough in an attempt to clear the airway. In some cases the person will need assistance to clear his/her airway.

⁸ Aspiration pneumonia is an inflammation of the lungs that develops after foreign items or substances are inhaled.

⁹ A pulmonary infiltrate is an abnormal substance denser than air in the lung, such as pus or blood, which is visible on chest x-ray and is typically associated with pneumonia.

¹⁰ Hypoxia is when the body does not have adequate oxygen supply.

The ED physician diagnosed the patient with aspiration pneumonia but did not order an arterial blood gas (ABG), a more definitive test to assess the patient's oxygenation status.

The patient received oxygen support, with improvement of oxygen saturations to 94 percent on 4 liters of oxygen per minute via nasal cannula (NC).¹¹ Subsequently, the community hospital transferred the patient to the facility. In route to the facility, ambulance personnel recorded a high heart rate and an oxygen saturation of 94 percent on 4 liters of oxygen via NC.

After arrival to the facility UCC, a physician evaluated the patient and admitted him with the diagnosis of viral bronchitis. The UCC physician documented that he did not believe the patient required antibiotics. While still in the UCC, the patient was noted to have oxygen saturations in the 82–84 percent range on 5 liters of oxygen per minute via NC. His oxygen was increased from 5 to 6 liters of oxygen per minute via facemask, and his oxygen saturation improved to 88 percent. The UCC physician did not order an ABG. The admitting physician did not order telemetry, a tool that provides continuous monitoring of a patient's heart rate and rhythm.

On admission to the floor, the patient had a temperature of 99.5 degrees and a high heart rate and respiratory rate with an oxygen saturation of 93 percent. The Acute Care Dysphagia screen on the nursing admission note template was not completed, although a pureed diet with thickened liquids was ordered. Overnight, the patient vomited several times. He received anti-nausea medication and was subsequently noted to be comfortable and sleeping. Respirations were described as “even and unlabored.” However, no vital signs were recorded for approximately 8 hours during the night.

Early the next morning, the patient had increased congestion, and his heart rate was higher than the previous day. A physician saw the patient, ordered blood work, an electrocardiogram,¹² a chest x-ray, and ABGs. He did not order telemetry monitoring. To accurately reflect oxygenation status, ABGs must be drawn from the arterial blood system (oxygenated blood), not the venous system (de-oxygenated blood). Results of the patient's ABG test were consistent with a venous sample. Blood work drawn that morning included a significantly elevated BNP,¹³ an indicator of heart failure. The chest x-ray report described infiltrates in both lungs.

About 2 hours later, the physician noted the BNP result in an EHR entry and ordered blood cultures and IV antibiotics. He documented that he would discuss the patient's case with the hospitalist at the community hospital. Within an hour, the patient was breathing 30 times per minute and was placed on a 100 percent oxygen via a non-

¹¹ A nasal cannula is a device used to deliver a mixture of air and oxygen through prongs placed into each nostril.

¹² An electrocardiogram is a test that checks the electrical activity of the heart.

¹³ BNP refers to brain type natriuretic peptide—a blood test that measures protein secreted in the blood in response to changes in pressure that occur with heart failure. BNP levels below 100 pg/mL indicate no heart failure. BNP levels of 100–300 pg/mL are generally inconclusive; while BNP levels above 300 pg/mL often indicate some degree of heart failure. However, BNP results must be interpreted in light of the patient's overall clinical status.

rebreather¹⁴ mask. The physician checked with a community hospital provider who advised he would return the call regarding availability of an ICU bed. He also noted that the patient looked a bit better on 100 percent oxygen via the non-rebreather mask and that he would contact the community hospital for possible transfer if the patient's condition worsened. We found no evidence in the EHR that the physician re-evaluated the patient before the patient was found pulseless in the early afternoon. Hospital staff were unable to resuscitate the patient.

EHR documentation reflects that the "most likely cause of death was acute aspiration causing respiratory arrest and then cardiac arrest."

Inspection Results

Issue 1: Quality of Care Issues

Inpatient Management

We could not substantiate the allegation that during the admission in which the patient died, the facility did not adhere to clinical care recommendations previously identified by the facility for the management of the patient's dysphagia. Onsite interviews and documentation in the EHR indicated staff knowledge of the patient's risk for aspiration; however, EHR documentation does not provide clear evidence of the steps taken to manage the patient's dysphagia. In addition, we found that the facility lacked a mechanism or process that would assist staff in quickly detecting previously identified dysphagia and aspiration risk. While not an allegation, we found that care of the patient's respiratory distress, which may have resulted from aspiration and/or heart failure, was not adequately addressed.

Despite the patient presenting to the UCC with an oxygen saturation of 94 percent on 5 liters of oxygen by NC, the physician did not order an ABG. When the patient's oxygen saturation declined further in the UCC, this also did not prompt measurement of a blood gas. The patient had a high respiratory rate with oxygen saturations in the low 90s while on a general medicine floor and ultimately required 100 percent oxygen delivered by a non-rebreather mask. Vital signs were ordered once every 8 hours. The only ABG drawn during the admission had an oxygen level that was either consistent with a venous sample or with the patient being in extreme distress. We did not find evidence that a change in management was considered when lab results revealed a markedly elevated BNP. Despite evidence of patient deterioration, vital signs were not requested more frequently nor was nursing staff directed to provide more than routine care. Telemetry was available on the unit; however, the physician did not order telemetry monitoring for the patient.

¹⁴ A non-rebreather is a mask that covers both the nose and mouth allowing a high level of concentration of oxygen to flow to the patient.

The dysphagia assessment for this admission was also not completed. However, the patient's dysphagia had been evaluated on previous swallowing studies, and the following recommendations regarding feeding the patient appeared in the EHR:

1. Puree consistency diet with some soft chewable cohesive¹⁵ foods allowed;
2. Nectar thick liquids fed with spoon and or with controlled drinking by the meal time assister - permitting small amounts at a time;
3. Let patient lean to left during eating - but, feed patient on the left side of mouth; If seated upright at midline, have patient rotate head to the right and feed on the left side of mouth;
4. Crush medications as per pharmacy recommendations and administer in puree or pudding consistency;
5. Verbal reminders to slow down and swallow and clear the left side of his mouth;
6. Have patient remain in at least 60 degree incline for 15 to 20 minutes following meals;
7. Consider alternative nutritional intake methods for the future.

A winter 2012 note, documented these recommendations. The primary physician who took care of the patient during his final admission had electronically acknowledged receipt of these recommendations at the time they were written.

During the admission discussed in this report, we did not find evidence that all of these aspiration precautions were documented as having been followed. We found two instances where nursing staff noted in the EHR that the patient needed assistance with meals.

According to documentation in the EHR, the admitting physician ordered thickened liquids and a pureed diet.

Through interviews, we determined that staff caring for the patient were aware that the patient had dysphagia, was at risk for aspiration, had been placed in an upright seated position while eating, had been fed by nursing staff, and was not left alone with food throughout his last inpatient admission. Due to the lack of documentation in the EHR, it is not possible to know if the patient was fed on the left side, whether staff checked for pocketing of food, his positioning following meals, and how closely the patient was monitored between meals. Therefore it is difficult to know all aspects of the patient's oral management and intake during the 23-hour admission that ended with the patient's death.

Bladder Management

We did not substantiate the allegation that the patient had not been diagnosed with a neurogenic bladder and received a suprapubic catheter solely to ease the burden on his previous caregivers.

¹⁵ Cohesive foods are foods that are semi-solid or solid, moist and stick together as opposed to dry and crumbly.

In late 2006, following a failed short-term trial of an indwelling Foley catheter,¹⁶ which had been placed at the request of caregivers to address concerns of ongoing incontinence, a referral was placed for an urologist to assess the need for a suprapubic catheter. The referral was completed in early 2007 when a non-VA urologist diagnosed the patient with urge incontinence¹⁷ and neurogenic bladder. The patient and family were consulted and agreed to have a suprapubic catheter placed at a non-VA facility. In 2010, a non-VA urologist was consulted to evaluate the ongoing need for the patient's suprapubic catheter. Based on this assessment, the patient's caregivers initiated a successful course of bladder retraining resulting in the removal of the suprapubic catheter in early 2011.

Outpatient Management

We did not substantiate the allegation that the facility failed to adequately address the patient's care needs as an outpatient causing him to become more acutely ill before eventually being admitted.

In the 2 years before his death, the patient had six inpatient admissions to the facility. In four of these cases, the patient had no encounters with facility medical staff in the 3 weeks preceding the admissions, although in one case he had been seen by physical therapy. The remaining two admissions to the facility took place within a 3-week period. Within this timeframe, the patient was seen in the facility UCC and the community ED for complaints of low blood sugar and increased cough. He had one brief inpatient stay at the community hospital. At each point of care, he was evaluated, and the assessment included chest x-ray, blood work, vital signs, and physical assessment. The patient's chest x-ray, blood work, and vital signs were normal up until his second ED visit to the community hospital, and upon his admission to the facility, at which time he had an abnormal chest x-ray. Contrary to the understanding of the complainant, records indicate that the patient was admitted to the facility for supportive nursing care and respite not because he needed hospitalization to manage his illness.

Issue 2: Denial of Care

Physical Therapy

We did not substantiate the allegation that the facility refused to provide physical therapy for the patient.

In fall 2010, upon request of the caregiver, a referral was made to physical therapy to assist the patient with conditioning. The patient received therapy for 3 months. The patient was discharged when he was no longer making progress and the therapist determined that treatment was no longer beneficial. Documentation indicates that

¹⁶ An indwelling Foley catheter is a hollow tube inserted through the urethra into the bladder. It remains in the body allowing urine to drain from the bladder into an external bag often attached to the leg.

¹⁷ Urge incontinence is the involuntary loss of urine associated with a sudden need or urge to urinate.

weights were ordered for the patient to use as part of his home exercise program upon discharge from therapy and that the caregiver agreed to the plan.

Refusal to Admit

We did not substantiate the allegation that on multiple occasions, the facility refused to receive the patient via ambulance when contacted by ambulance personnel transporting the patient. The complainant was unable to provide dates when this occurred or the names or positions of facility staff that were involved.

A VA patient being transported by ambulance has the right to request to go to a VA if his/her condition can be managed at the VA facility. The VA will provide payment for ambulance services for eligible veterans.

The facility does not have an ED and does not accept emergent, unstable “911” patients. The facility does have an UCC that is equipped to receive stable patients by ambulance. When a patient, arriving by ambulance or other transportation, cannot be accepted because the appropriate level of care is not available, the facility has a process to refer patients for non-VA care. In situations when the facility cannot accept admissions due to issues such as staffing levels or natural disaster, the facility is considered to be “on diversion” status.

We reviewed records including the patient’s visits to the community hospital emergency department, six VA admissions, and three non-VA admissions for the 2 years prior to the patient’s death. We also reviewed payments made by VA for ambulance transport of the patient and dates when the facility was on diversion status.

The facility paid for ambulance services on four dates during the review period. Three of the four service dates involved transport of the patient to the VA. Only the fourth, which was for transport of the patient from his home to the community hospital ED, had the potential to involve a request to go to the VA that could have been denied. In reviewing this event, we found documentation indicating that caregivers “prefer patient be evaluated at ED.” The remaining admissions to the community hospital did not involve transportation paid for by the VA and occurred on dates when the facility was not on diversion status and was accepting patients.

The available information does not provide evidence to substantiate the allegation that the facility refused to receive the patient upon being contacted by ambulance personnel.

Issue 3: Other Findings

Facility Internal Review Process and Response to an Inpatient Death

Because of the quality of care concerns identified in the care of this patient prior to his death, we examined the credentialing and privileging files for the providers involved with the case and the facility’s and VISN’s internal review process and response to this event.

VHA Directive 2010-025 and facility Medical Center Memorandum 11-13, both titled *Peer Review for Quality Management*, outline circumstances requiring consideration of peer review to include:

“Mortality Review. All deaths occurring within the medical center and those occurring in the community setting that are brought to the attention of the medical center and have identified concerns (including all suicides) must be screened against death review criteria.”

Occurrence screens are a tool used to gather and track comparable data. One such occurrence screen available within VHA is “mortality during inpatient hospitalization.” When this occurrence screen is triggered, the peer review¹⁸ process is to be considered. Although not an allegation, our review found that internal as well as external peer reviews related to the patient’s death were completed for some, but not all involved staff and that the peer reviews of this case did not address the full scope of quality issues contributing to the patient’s outcome.

While the patient died during an inpatient hospitalization, the facility did not classify it as an unexpected death or adverse event. When a death is considered an adverse event, VHA policy requires that the Patient Safety Manager be notified and determine the Safety Assessment Code score of the event. Based on the score given, there may be a subsequent requirement to conduct an in-depth focused review, such as a root cause analysis (RCA). As a result of the facility not identifying this as an adverse event, an in-depth focused review was not triggered. The VISN conducted a review; however, because the VISN report is protected under privacy laws, further discussion of the objectives, findings, and recommendations, if any, is prohibited by law.

At the time of the patient’s death, the facility had 10 providers privileged to provide inpatient care. In the course of reviewing this case, we looked at the credentialing and privileging files for three providers who cared for this patient. The privileging form used by the facility states that for skilled procedures, the proficiency of the practitioner must be maintained and that verification of training and/or experience is required. We found that one provider involved in the care of this patient was privileged to insert central lines, but evidence was lacking to indicate that the provider had participated in recent training and/or performance of this skill. VHA Handbook 1100.19, *Credentialing and Privileging*, directs VA facilities to base privileges on current competence, and when delineation is based on experience, the credentials record is to include documentation of numbers, types, and outcomes of related cases. All of the reviewed Ongoing Professional Practice Evaluations lacked criteria and data specific to the privileges held by the providers. The patient population and scope of services provided by the system is such that opportunities are limited for providers to maintain proficiency in procedures, such as central line placement.

The facility has implemented multiple new processes. Inpatient physician staffing has transitioned to a hospitalist model and now includes a formalized process to

¹⁸ Peer Review is a critical review of care performed by a peer or group of peers.

communicate patient information from shift to shift. Abnormal vital sign parameters have been identified to clarify when nursing staff are to contact physicians, and guidelines have been put in place to assist physicians in determining when to transfer patients to a higher level of care than can be provided at the facility. The frequency with which vital signs are to be taken has changed from once every 8 hours to once every 4 hours. Processes are in place to provide daily consultation of inpatient management by VHA specialists at a partner tertiary care center, and there is a renewed commitment to staff education to ensure ongoing competencies using tools to include a medical simulation lab.

Conclusions

We could not substantiate the allegation that during the admission in which the patient died, the facility did not adhere to clinical care recommendations previously identified by the facility for the management of the patient's dysphagia. Onsite interviews and documentation in the EHR indicate staff knowledge of the patient's risk for aspiration; however, EHR documentation does not provide conclusive evidence of the steps taken to manage the patient's dysphagia. In addition, we found that the facility lacked a mechanism or process that would assist staff in quickly detecting previously identified dysphagia and aspiration risk. We identified concerns regarding the management of the patient's respiratory distress prior to his death and the facility's internal review of this event.

We did not substantiate the allegation that the patient received a suprapubic catheter solely to ease the care on previous caregivers.

We did not substantiate the allegation that the facility failed to adequately address the patient's care as an outpatient causing him to become more acutely ill before being admitted. We found that the care provided as an outpatient was not a factor in his need for inpatient admissions.

We did not substantiate the allegation that the facility refused to provide physical therapy for the patient.

We did not substantiate the allegation that the facility refused to receive the patient via ambulance on multiple occasions when contacted by ambulance personnel transporting the patient.

We found opportunities to align actual practice in the area of provider privileging with local facility and VHA policies.

While the VISN conducted a review of the patient's death, further discussion of the objectives, findings, and recommendations, if any, is prohibited by law.

Recommendations

1. We recommended that the Facility Director ensure that staff comply with Veterans Health Administration and facility policies and practices related to the management of

dysphagia, including assessment and documentation of a patient's response to the provided care recommendations and aspiration risk precautions.

2. We recommended that the Facility Director implement applicable recommendation(s) from previous event-related reviews, if any.

3. We recommended that the Facility Director review local privileging processes and ensures compliance with local policy and Veterans Health Administration Handbook 1100.19.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

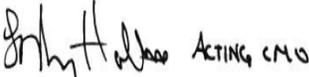
Date: February 20, 2015

From: Director, Rocky Mountain Network (10N19)

Subj: **Draft Report**—Healthcare Inspection – Quality of Care Issues, Sheridan VA Healthcare System, Sheridan, WY

To: Director, Seattle Regional Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the Healthcare Inspection report for Quality of Care Issues at the Sheridan VA Healthcare System and concur with the responses as provided by the Acting Medical Center Director.
2. If you have any questions or would like to discuss this response, please contact Ms. Susan Curtis, VISN 19 HSS at 303-639-6995.


for Ralph T. Gigliotti, FACHE

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: February 20, 2015

From: Director, Sheridan VA Healthcare System (666/00)

Subj: **Draft Report**—Healthcare Inspection – Quality of Care Issues, Sheridan VA Healthcare System, Sheridan, WY

To: Director, Rocky Mountain Network (10N19)

1. I have reviewed and concur with the findings in this report. Specific corrective actions have been provided for the recommendations.
2. If you have any questions or would like to discuss this response, please contact Jane Scott, Quality Manager, at 307-675-3165.

(original signed by:)

Shella Stovall

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that staff comply with Veterans Health Administration and facility policies and practices related to the management of dysphagia, including assessment and documentation of a patient's response to the provided care recommendations and aspiration risk precautions.

Concur

Target date for completion: June 1, 2015

Facility response:

An interdisciplinary team that will include providers, nursing, dietitian/nutrition services, speech pathology, pharmacy, social work, and occupational therapy will conduct a review of VHA Directive 2006-032 Management of Patients with Swallowing (Dysphagia) or Feeding Disorders and the VHA Dysphagia Evaluation Guidelines to ensure that we are complying with all required elements.

Chart reviews were completed to assess nursing documentation of dysphagia assessments upon admission for all Acute Medicine Unit patients from May 2014 through January 2015. Compliance varied from 91-100%, with an average of 98%.

Further monitoring, including assessment and documentation of the Acute Medicine Unit dysphagia patients' response to provided care recommendations and aspiration risk precautions, will be accomplished through quality indicator monitoring and reported quarterly to the Quality Oversight Board until 90% compliance has been achieved.

Recommendation 2. We recommended that the Facility Director implement applicable recommendation(s) from previous event-related reviews, if any.

Concur

Target date for completion: April 30, 2015

Facility response:

Recommendations from previous event-related reviews were implemented as of May 9, 2014.

Recommendation 3. We recommended that the Facility Director review local privileging processes and ensures compliance with local policy and Veterans Health Administration Handbook 1100.19.

Concur

Target date for completion: June 30, 2015

Facility response:

A review was conducted to compare local privileging processes with the facility's MCM 11-12 Delineation of Clinical Privileges and VHA Handbook 1100.19 Credentialing and Privileging. Processes will be aligned to ensure compliance with local MCM and VHA Handbook. Privileges for skilled procedures will include Ongoing Professional Practice Evaluation data for all future privileges granted to physicians.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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