



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Mismanagement of Care and Delayed Adverse Event Reporting Robert J. Dole VA Medical Center Wichita, Kansas

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient of the Salina, KS Community Based Outpatient Clinic (CBOC).

A complainant alleged that the care of a patient, regularly seen at the CBOC, was mismanaged. In March 2010, he presented to the CBOC on a “walk-in” unscheduled basis. When the severity of his illness was ultimately recognized that day, he was sent by ambulance to a non-VA hospital where he died the next day. It was also alleged that in the aftermath of the patient’s death, there were numerous quality management and administrative missteps including: (1) a possible attempt by Salina CBOC and/or Robert J. Dole VA Medical Center, Wichita, KS (facility) staff to cover up mismanagement of the patient’s care, (2) that the case was not conveyed to appropriate Veterans Health Administration (VHA) officials within VHA’s chain-of-command, such as Veterans Integrated Service Network (VISN) 15 staff, (3) that a Root Cause Analysis (RCA) performed in the aftermath of the patient’s death may have been perfunctory and lacking in sufficiently strong recommendations to prevent a future recurrence of the type of incident in question, and (4) that management may have taken adverse action against the individual who reported the incident.

We substantiated the allegation that the care of the patient was mismanaged. We are unable to determine and do not assert that a more prompt medical response would have resulted in preventing the patient’s death. We found lack of proper, timely reporting of this death at multiple levels, but could not substantiate that there was an institutional attempt by Salina CBOC or facility staff to “cover-up” the mismanagement of the patient’s care; that the RCA performed in the aftermath of the patient’s death was perfunctory or lacking in sufficiently strong recommendations; and that facility management may have taken adverse action against the individual who reported the incident.

We found inadequate triage practices existed at the CBOC; that there was inadequate physician supervision and inadequate physician availability on the day of the events in question; that while a thorough RCA as well as one peer review was conducted, oversight reviews of all the relevant clinicians who were, or should have been, involved in the patient’s care were not performed; and that adversarial staff relationships existed at the CBOC which may have impeded effective staff communication about the patient in this case. Additionally, while we did not substantiate that the RCA performed in the aftermath of the patient’s death was perfunctory or insufficiently strong in its recommendations, we did find that issues identified still remained to be fully corrected.

The VISN Acting Director and Medical Center Director agreed with our findings and six recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Director, Veterans Integrated Service Network (10N15)

SUBJECT: Healthcare Inspection – Alleged Mismanagement of Care and Delayed Adverse Event Reporting, Robert J. Dole VA Medical Center, Wichita, Kansas

Purpose

The Department of Veterans Affairs, Office of Inspector General Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding the quality of care received by a patient of the Salina, KS Community Based Outpatient Clinic (CBOC), a satellite clinic of the Robert J. Dole VA Medical Center (facility) in Wichita, KS. This patient died less than a day after being seen at Salina CBOC. Secondly, the quality management (QM) and administrative responses that took place in the aftermath of this patient's death were reviewed. Thus, the purpose of this inspection was to review both the actual quality of care received by the patient in question as well as Salina CBOC and the facility's responses to the patient's death.

Background

Allegations

A complainant alleged that the care of a patient of Salina, KS, CBOC, who died the day after being seen at the CBOC, was mismanaged. This patient was a regular patient of the CBOC. In March 2010, he presented to the CBOC on a "walk-in" unscheduled basis. When the severity of his illness was ultimately recognized that day, he was sent by ambulance to a non-VA hospital, where he died the next day.

It was also alleged that in the aftermath of the patient's death, there were numerous QM and administrative missteps including: (1) a possible attempt by Salina CBOC and/or facility staff to cover up mismanagement of the patient's care, (2) that the case was not conveyed to appropriate Veterans Health Administration (VHA) officials within VHA's chain-of-command, such as Veterans Integrated Service Network (VISN) 15 staff, (3) that a Root Cause Analysis (RCA) performed in the aftermath of the patient's death may have been perfunctory and lacking in sufficiently strong recommendations to

nts prevent a future recurrence of the type of incident in question, and (4) that management may have taken adverse action against the individual who reported the incident.

The Facility

The facility is located in Wichita, KS. It provides a broad range of inpatient and outpatient health care services, including primary, specialty, acute, and extended care. The facility has 41 hospital beds and 40 Community Living Center beds. The facility is part of VISN 15 and serves a veteran population of approximately 100,500 in 59 Kansas counties. Additional outpatient care is provided at six CBOCs in Ft. Dodge, Hays, Hutchinson, Liberal, Parsons, and Salina, KS.

CBOCs were established to provide more convenient access to care for veterans living distant from a VA medical center. The Salina CBOC opened in June 2002, and is VA leased and staffed. It is located approximately 90 miles from the facility and is open Monday–Friday from 8:00 a.m.–4:30 p.m. The CBOC workload in fiscal year 2010 was 2,548 unique patients with a total of 12,280 encounters.

Salina CBOC’s patient panel is distributed between two primary care (PC) teams. Staff reported that there was no specific process for assigning patients to a PC team. Each team was responsible for triaging walk-in patients that did not have appointments.

Veterans are required to receive one standard of care at all VHA health care facilities. CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

Scope and Methodology

We conducted a site visit from August 1–3, 2011, to both the facility and Salina CBOC. Prior to our visit, we interviewed the complainant(s) in order to clarify the initial allegations. We interviewed facility and CBOC administrative, clinical, and support staff. We also interviewed VISN 15 staff.

We reviewed medical and administrative records, QM documents, and facility and VHA policies and procedures. We also reviewed relevant Kansas statutes regarding scope of practice for physician extenders, such as physician assistants and nurse practitioners.

The patient in question had received care at non-VA medical institutions both prior to and after his March 2010, encounter at Salina CBOC. We obtained the relevant medical records for this care from these institutions.

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 a man in his eighties with several chronic medical problems including coronary artery disease; premature atrial contractions; hypertension; hyperlipidemia; Type II diabetes mellitus with diabetic nephropathy with microalbuminuria; gastrointestinal complaints; stable tremor; stress; and insomnia. The patient's medications included citalopram, glipizide, lisinopril, polyethylene glycol, simvastatin, and aspirin.

The patient received his primary care at the Salina CBOC.

In March 2010, the patient was seen by a clinician at the Salina CBOC in a routine follow-up visit. At that time, he stated that he was awakening during the night and only getting about 3–4 hours of sleep nightly. He also complained of constipation and gastroesophageal reflux disease symptoms (GERD). For example, he occasionally experienced an unpleasant taste in his mouth that he attributed to acid reflux. During this visit, the patient also complained of diminished energy with episodic daytime napping. On physical examination an “irregular” heart rhythm was noted, but was not further characterized. No other abnormal physical findings were documented in the medical record for that day's visit. A particularly relevant negative finding on that CBOC visit—not necessarily at the time, but in relation to subsequent events—was that the patient had no clubbing, cyanosis, or edema of his extremities. A Patient Health Questionnaire-9 (PHQ-9) screening test¹ was suggestive of moderate depression.

A detailed plan to address the patient's multiple symptoms was documented in his medical record. The clinician believed that the patient had situational stress and “might benefit from counseling.” Mirilax® (polyethylene glycol) was prescribed for constipation, and it was also hoped that treatment of the patient's constipation might have an ameliorating effect on his GERD symptoms. Citalopram was prescribed for insomnia and depressive symptoms. Also, the patient was advised to take Advil® PM (ibuprofen and diphenhydramine citrate) for insomnia.

Five days later, the patient presented to a local urgent care facility with pedal edema and hallucinations. A physician at that facility documented:

The patient has been taking Advil PM in the evenings apparently to help him sleep. He says that he has been hallucinating over the last day or two, seeing gremlins and other things. He has not had any hallucinations today. He took his last dose of Advil PM last night. He also has noticed that his legs have swelled a little bit.

¹ The PHQ-9 is a nine-item depression screening tool. See <http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/> [accessed 9/5/2011]

On physical examination the patient was alert, oriented, and not in acute distress. His vital signs showed a blood pressure of 100/62 and pulse rate of 60 beats per minute (bpm) (normal resting 60–100 bpm). Respiratory rate was not recorded. His lungs were clear and there was no evidence of respiratory distress. His heart rhythm was regular. Examination of the patient’s lower extremities revealed “some pitting edema below the knees with the right greater than the left.”

The physician who evaluated the patient concluded that the patient’s hallucinations were most likely due to diphenhydramine, which was one of the ingredients in the patient’s recently prescribed Advil® PM. The patient was instructed to discontinue Advil® PM, to elevate his legs for 15–20 minutes four times daily, and he was to call his primary care provider at Salina CBOC the next day.

The next day, the patient presented to Salina CBOC in the morning as a “walk-in” unscheduled patient. The patient’s time of arrival at the CBOC was between 8:00 a.m. (the time the CBOC opened) and 9:00 a.m. A more precise time of arrival could not be established as there was no sign-in mechanism at the CBOC and there was varying testimony on this point. We believe that the outside window of his arrival was 9:00 a.m.

As well as being unable to know the precise time of arrival, the patient’s clinical appearance at the time of arrival—and indeed for all of that morning—is also uncertain due to poor documentation and varying testimony.

In an initial note timed at 10:41 a.m., a clinician documented that the patient stated that he had been to a local urgent care facility:

[F]or severe painful swelling of the lower extemeties [sic]. [The patient] [s]tates that the swelling started yesterday morning. Swelling is on both of the lower extremities. [An urgent care physician told him that it could be the Advil PM that he started that caused the swelling. [The] [p]atient also now states that he is scared to get up in the middle of the night and is having nightmares, states that he is seeing Gremlins.

This note also documented a new symptom relative to the patient’s local urgent care facility visit the day before, in that the “Patient also states that he has had a cough that is causing him chest pain after coughing.”

On physical examination, vital signs recorded at 11:48 a.m. showed a blood pressure of 110/78, pulse rate of 139 bpm, respiratory rate of 18, and temperature of 98 degrees Fahrenheit. Pain was rated as 1, the least on a scale of 1–10.

An electrocardiogram (EKG) was obtained at 11:21 a.m., and it showed atrial fibrillation with a rapid ventricular response. Also, the clinician requested the patient's notes from his urgent care facility visit of the previous day. However, as of 10:41 a.m. charting the urgent care facility records had not been received at the CBOC.²

The clinician noted, "Will discuss [the patient] with provider," and the patient was referred to a CBOC clinician, who was both the senior clinician on duty at the Salina CBOC that morning and the patient's regular PC provider. We were told that the patient was evaluated that same morning by the senior clinician at the CBOC; however, the medical record does not clearly document the clinician's findings or assessment from that morning. We were told by the clinician that the patient was not unstable or in distress at that time. The patient was sent home from the CBOC with a 24-hour Holter monitor, which was ordered due to the patient's tachycardia (rapid heart rate).

After departing the CBOC, the patient's urgent care facility records from the previous day were received at the CBOC via fax. The clinician told OHI that in the urgent care facility record the patient's pulse rate had been 60 bpm the day before. While at the CBOC the next day, it "was anywhere from 130–150 [bpm]." Therefore, the clinician attempted to consult a physician at the facility in Wichita for advice as to how to proceed.

According to the clinician, a physician at the facility could not be reached, so instead a cardiology Advanced Registered Nurse Practitioner (ARNP) was consulted. As a result of that conversation, it was decided to contact the patient and recommend that he be seen in an emergency room (ER) in Salina that same day.

However, instead of going directly to an ER in Salina, the patient returned to the CBOC. OHI was told that the clinician's intention was to get the patient to a private medical center near the CBOC, but that the patient had to be first routed to the CBOC if VA was to reimburse ambulance trip costs to the private medical center.

When seen the second time that day at Salina CBOC, the patient was noted to be short of breath, and his skin appeared to be "a little more pale and [with] almost a purple tint." His lungs were clear, his heart rhythm was irregular, and there was 1–2+ pitting edema [location not specified, but presumably the lower extremities]. At this time, the clinician's assessment was that the patient had atrial fibrillation with a rapid ventricular response. The clinician noted:

I have called and spoke with ARNP [nurse named] in cardiology, and after evaluating patient further feel he should go to ER for further evaluation

² While OHI was ultimately able to obtain the patient's local urgent care facility medical record of the March visit, we were unable to obtain the actual *fax copy* retrieved at Salina CBOC the next day. Thus, we could not ascertain with certainty what time the local urgent care facility records reached Salina CBOC; however, testimony leads OHI to conclude that the fax came into the CBOC the next afternoon.

now. He is definitely symptomatic and in review of records from local urgent care facility yesterday pt [the patient] is now tachycardic and dyspneic [short of breath]. ER here and will transport to a private medical center.

The patient was taken by ambulance from the CBOC to a private medical center, and was seen there at 5:35 p.m. At that facility, extensive laboratory work as well as a chest x-ray, EKG, echocardiogram, and computed tomography (CT) angiogram of the chest were obtained. The patient was admitted to the Intensive Care Unit.

These tests were remarkable for an elevated D-dimer, elevated brain natriuretic peptide, and elevated troponin. The EKG revealed atrial fibrillation with a rapid ventricular response. The chest x-ray showed borderline cardiomegaly, but was without a definite infiltrate. The CT angiogram was read as follows: "There does appear to be pulmonary emboli in the right [lung] base posteriorly as well as bilateral effusions."

At the private medical center, the patient was started on Lovenox® (enoxaparin), an anticoagulant drug used in the treatment of blood clots and pulmonary emboli. He initially appeared to improve.

The next day, the patient developed low blood pressure. At 6:39 p.m., he suddenly became unresponsive and went into cardiopulmonary arrest. While he was initially able to be successfully resuscitated, further cardiopulmonary arrests ensued. Ultimately, the patient did not regain consciousness and was unable to sustain a viable heart rhythm despite extensive pharmacologic interventions and multiple electrical defibrillations. After more than an hour and a half of resuscitative efforts that were unsuccessful in producing a viable and sustainable cardiac rhythm, in consultation with the patient's wife, further efforts were halted. The patient died that evening.

Inspection Results

Issue 1: Quality of Care

We substantiated the allegation that the care of a patient of Salina CBOC, who died the day after being seen at the CBOC, was mismanaged.

In March 2010, the patient presented, during an unscheduled visit to the CBOC, with new onset atrial fibrillation with a rapid ventricular response. This condition required prompt evaluation in a hospital setting.

Additionally, other process issues are raised in an analysis of the patient's quality of care. The first is the amount of elapsed time that this patient had to wait to be seen. This issue is clouded by a lack of documentation as to precisely when the patient entered the CBOC and the varying descriptions of his appearance while he was waiting to be seen.

However, it is all but certain that the patient had entered the CBOC by 9:00 a.m., a clinician's note is timed at 10:41 a.m. but does not have vital signs recorded, and vital signs are not documented until 11:48 a.m.

Further, on the issue of timeliness of the patient's evaluation on that morning in March 2010 while some clinicians testified that the patient did not seem in distress, other CBOC staff stated that he was in distress. This is unresolvable, but the discrepancy in testimony is disturbing.

Finally, testimony indicated that as a result of the conversation between a clinician and a facility ARNP, the clinical assessment was to send the patient to an ER. However, ostensibly for reimbursement reasons, instead of going directly to an ER in Salina, the patient returned to the CBOC, was re-evaluated there, and only then was sent via ambulance to a private medical center.

Issue 2: Initial Triage and Assessment

We found that inadequate triage practices existed at the CBOC. There was no formalized process to assess and triage patients arriving unscheduled, with or without emergent symptoms. For example, at the time of the patient's unscheduled March 2010 visit to the CBOC, there was no patient sign-in sheet or defined triage process in place.

CBOCs must comply with applicable VHA and local requirements, and should have a CBOC specific policy or standard operating procedure defining how health emergencies are handled.³ We could not identify a local policy or procedure in place that defined the management of health emergencies at the CBOC. Almost a year and a half after the patient's death and almost a year after the case had been reviewed by the facility, there still were no triage policies specific to the CBOC. Managers referred us to facility PC policies, but these do not negate the need for CBOC specific policies.

Issue 3: Supervision and Scope of Practice

We found that there was both inadequate physician supervision and inadequate physician availability on the patient's unscheduled March 2010 CBOC visit.

The Kansas State Board of Healing Arts specifies that some physician extenders must be under the supervision of a physician. The practice of a clinician includes provision of medical services within the education, training, and experience of the clinician as are delegated by the responsible physician. Physician extenders practice in a dependent role with a responsible physician, and may perform those duties and responsibilities through delegated authority or written protocol.⁴ VHA clinician requirements are consistent with

³ VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

⁴ KSBHA statute 65-28a08 <http://www.ksbha.org/statutes/paact.html>

Kansas requirements.⁵ However, not only was a physician not on site on the day of the event in March 2010, but when the clinician attempted to reach a physician at the facility, he was unable to do so successfully.

VHA Directive 2004-029 *Utilization of Physician Assistants (clinicians)* notes that “The COS [Chief of Staff], or the chief of the clinical service, must appoint a member of the regular physician staff to be the official supervisor (hereafter designated as the “supervising physician”) of each clinician.” Directive 2004-029 further notes that “it is imperative that the scope of each supervising physician’s duties be clearly spelled out so that there is no ambiguity as to who is responsible for the action of the clinician at any time or in any circumstance,” “the supervising physician retains both professional and personal responsibility for any act of the clinician,” and “when the supervising physician is unavailable for his supervisory duties (such as vacation or extended leave), another qualified physician must be designated as supervisor.” We found that these mandates were not fully adhered to at Salina CBOC. A physician supervisor was not readily available, when required.

While on site, we also found that LPNs perform initial patient assessments. Kansas state nursing regulations state that initial patient assessment is beyond the scope of practice for an LPN.

Issue 4: Adverse Event Reporting and Review of Patient Death

We did not substantiate the allegation that there was an institutional attempt by Salina CBOC or the facility staff to “cover-up” the mismanagement of the patient’s care.

There were a series of QM and administrative missteps in the aftermath of the patient’s death, which led to a 4 month delay in beginning to adequately review this case. Overall, there were deficiencies in the reporting processes that took place which are discussed in this section and others. However, these deficiencies notwithstanding, in this review we found no evidence of institutional “cover-up” or deliberate hiding of the facts of the case. On an individual level, we were troubled by discrepancies in testimony. Most notably, we heard quite varying descriptions of the patient’s appearance on the morning he presented to the CBOC as a walk-in, unscheduled patient. Better triage, as already discussed, and documentation, would have resolved many of these issues.

QM Processes

The patient’s death occurred in March 2010, but the facility Patient Safety Officer stated the event was not reported until July 2010. Furthermore, the report of the patient’s death came to the facility via an anonymous “Duty to Report” contact, as opposed to through expected QM channels.

⁵ VHA Directive 2004-029, *Utilization of Physician Assistants (clinicians)*, July 2, 2004.

CBOC staff should have reported the patient's death to the facility Patient Safety Office or QM office for a death review. It is documented in the medical record that the CBOC staff learned from the patient's family that he had died the day after he was transported to the private medical center. Since the patient died within 24 hours of a CBOC visit and within 24 hours of a VA funded admission to the private medical center, the facility should have reviewed the patient's death.

The facility QM Manager became aware of the patient's death 4 months after it occurred through a monitoring process the QM department developed with the fee basis program, and about the same time an anonymous report was filed through the facility's electronic safety reporting system. However, in mid-March 2010, a facility QM review transfer coordinator documented knowledge of the patient's death. Thus, although the patient died in a non-VA facility, multiple facility and CBOC responsible parties knew of the patient's death in its immediate aftermath. Nevertheless, no reviews—QM or otherwise—of the patient's care were performed at that time.

The review system was finally activated by the anonymous "Duty to Report" contact system. This notification sufficiently alerted senior facility staff to the case, and an RCA of the event and a peer review were performed.

Root Cause Analysis

We did not substantiate the allegation that the RCA performed in the aftermath of the patient's death was perfunctory or lacking in sufficiently strong recommendations to prevent a future recurrence of the type of incident reviewed.

The RCA thoroughly covered the relevant aspects of this case. For example, it appropriately conducted a complete review of the patient's records in VA's computerized patient record system; reviewed CBOC staff documents such as position descriptions, functional statements, competency assessments, scopes of practice, clinical privileges, and Providers Ongoing Professional Practice Evaluations; clarified scope of practice with the Kansas Nursing Board; interviewed CBOC staff; and reviewed pertinent VA directives, policies, and procedures. It developed a detailed patient history and timeline of the events that occurred in March 2010.

The RCA made 31 recommendations in areas such as training, and education of staff regarding the "Duty to Report" system, and improving CBOC patient check-in and triage processes.

The RCA was problematic in a few aspects. Most notably, there was no physician on the RCA. This is critical, because while the case does indeed raise many CBOC process issues that might be adequately covered without a physician's input, at its heart, the case

centers about the medical management of an unstable cardiovascular patient and staff supervision. These are both issues in which physician input is essential.

Facility staff provided us with progress reports from the RCA's numerous recommendations. However, those progress reports were undated making it difficult to determine when actions were completed and when they were reported to senior leaders. In a similar vein, we found that facility senior leaders had not signed off on these progress reports. It appeared that some actions that were supposed to have been completed by January 2011 had not been implemented.

Peer Review

A Peer Review of the case was performed in August of 2010, by a facility clinician. Pertinent findings of this Peer Review mirrored both OHI findings and the RCA findings.

Other Oversight

While a thorough RCA was performed and a peer review was conducted, we found no oversight review(s) addressing supervision or scope of practice.

Reporting to the VISN

We substantiated the allegation that the case was not aggressively reported to appropriate VHA officials within VHA's chain-of-command, such as VISN 15 senior staff.

The case was reported to VISN 15 at the conclusion of the RCA. Given the seriousness of the outcome in this case, and the numerous process and systems issues raised, it would have been appropriate to have notified the VISN 15 of the case earlier. However, we also could not identify a policy that mandated earlier notification of the RCA-in-progress. Also, the facility did not create an "Issue Brief" (IB) about the case for VISN 15 after senior staff learned of it via the "Duty to Report" system. Arguably, the case meets the VHA's IB guidance to create IBs "to provide clear, concise and specific factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care." Likewise, a "Heads Up Message," which VHA describes as "a notification designed to allow facility and VISN leadership to provide a brief synopsis of the issue while facts are being gathered to be submitted as an Issue Brief within the appropriate timeframe, usually within 24 hours (not to exceed 48 hours)," may have been appropriate.

Issue 5: Alleged Reprisal

We did not find evidence of reprisal taken against CBOC or other facility staff.

Issue 6: Staff Dynamics

We found that adversarial staff relationships existed at the CBOC. This may have impeded communication within the CBOC, and prevented staff from effectively communicating with one another regarding concerns about the patient in this case.

The Joint Commission states that “safety and quality patient care is dependent on teamwork, communication, and a collaborative work environment.”⁶

Conclusions

We substantiated that a patient received substandard care during a March 2010, “walk-in” visit at the Salina CBOC. The patient received insufficient triage, inaccurate assessment of the severity of his presenting symptoms, and delayed access to emergency medical care. Contributing factors included unclear triage procedures, the lack of a CBOC health emergency policy, inadequate supervision, and possibly, inter-staff conflict.

Additionally, the facility’s QM and administrative processes did not identify this patient case for review, despite his death within 24 hours of being seen at the CBOC. It was only when an anonymous “Duty to Report” contact informed facility staff of the case that appropriate actions were initiated.

In response to the report of the patient’s death and concerns about the care received at the CBOC, the facility conducted an RCA and a peer review. As a result, numerous constructive action steps have been recommended to improve CBOC processes. We also concluded that oversight reviews addressing supervision and scope of practice were indicated.

We are unable to determine and do not assert that a more prompt medical response would have resulted in preventing the patient’s death.

Recommendations

Recommendation 1. We recommended that the Medical Center Director continues aggressive actions to implement the RCA’s recommendations.

Recommendation 2. We recommended that the Medical Center Director ensures that physicians supervising PAs are designated and readily available at all times.

Recommendation 3. We recommended that the Medical Center Director ensures that CBOC’s have clear and consistent triage practices and policies to address health emergencies, as required by VHA.

⁶ TJC Sentinel Event Alert, Issue 40, *Behaviors that undermine a culture of safety*, July 9, 2008.

Recommendation 4. We recommended that the Medical Center Director ensures that all CBOC staff are trained and encouraged to utilize the facility’s “Duty to Report” system.

Recommendation 5. We recommended that the Medical Center Director ensures that clinical staff involved in this case are peer reviewed.

Recommendation 6. We recommended that the Medical Center Director ensures that problematic staff relationships are appropriately addressed and resolved.

Comments

The VISN Acting Director and Medical Center Director concurred with the findings and recommendations and provided acceptable action 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

VISN Acting Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 13, 2012

From: Acting Director, Veterans Integrated Service Network
(10N15)

Subject: **Healthcare Inspection – Alleged Mismanagement of Care and
Delayed Adverse Event Reporting, Robert J. Dole VA Medical
Center, Wichita, Kansas**

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

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

1. Attached is the Robert J. Dole VA Medical Center, Wichita, KS response to the Healthcare Inspection Report. I have reviewed the report and concur with the responses.
2. If you have questions regarding the report, contact the VISN 15 Office at 816-701-3000.



William P. Patterson, MD, MSS
Acting Director, VISN 15 (10N15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 13, 2012

From: Director, Robert J. Dole VA Medical Center

Subject: **Healthcare Inspection – Alleged Mismanagement of Care and Delayed Adverse Event Reporting, Robert J. Dole VA Medical Center, Wichita, Kansas**

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

1. The Director and Leadership has reviewed the draft inspection report of the Alleged Mismanagement of Care and Delayed Adverse Event Reporting conducted by the Office of Inspector General (OIG).
2. We concur with the recommendations of the OIG and appreciate the opportunity to make improvements in our patient care. Our response to the recommendations is attached.

Tom Sanders

THOMAS J. SANDERS, FACHE

Director, Robert J. Dole VA Medical Center, Wichita, Kansas (589A7/00)

**Director's 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's report:

OIG Recommendations

Recommendation 1. We recommended continued aggressive actions to implement the RCA's recommendations.

Concur

Target Completion Date: 3/1/2012

Facility's Response:

Medical Center Leadership will continue to aggressively implement the recommendations from the RCA.

Status: In Progress

Recommendation 2. We recommended that the Medical Center Director ensures that physicians supervising clinicians are designated and readily available at all times.

Concur

Target Completion Date: 3/1/2012

Facility's Response:

The Supervising Physicians for 'Physician Assistants' (clinicians) are designated in each clinician Scope of Practice. In the absence of the supervising physician, the Director, Primary Care or her designee serves as the alternate supervising physician and is available through the Primary Care Office or by pager number which is listed on the Primary Care Beeper List and in the VISTA phone book. A draft policy providing specific guidance has been written and is in the concurrence process.

Status: In Progress

Recommendation 3. We recommended that the Medical Center Director ensure that CBOC's have clear and consistent triage practices and policies to address health emergencies, as required by VHA.

Concur

Target Completion Date: 3/1/2012

Facility's Response:

The 'Scope and Conduct of Practice in the Community Based Outpatient Clinics' has been drafted and is currently going through the concurrence process. This policy provides guidance on managing health emergencies in the CBOCs.

Status: In Progress

Recommendation 4. We recommended that the Medical Center Director ensure that all CBOC staff are trained and encouraged to utilize the facility's "Duty to Report" system.

Concur

Target Completion Date: Completed

Facility's Response:

The Medical Center Director has provided education to all staff regarding the Duty to Report process at forums such as All Employee Forum and staff meetings including the Primary Care/CBOC staff meeting. The Patient Safety Manager also provides this education to all staff on a regular basis, including the Primary Care/CBOC Staff Meetings on 1/6/11 and 1/5/12 as well as at 'New Employee Orientation'. Staff members have been educated to use the 'Duty to Report' process to communicate any patient/staff related concerns, adverse events, including patient deaths. Additionally, the CBOC Coordinator has educated the CBOC staff about their responsibility to use the facility's 'Duty to Report system' for incident reporting .

Status: Completed

Recommendation 5. We recommended that the Medical Center Director ensure that all clinical staff involved in this case are peer reviewed.

Concur

Target Completion Date: 3/1/2102

Facility's Response:

Peer Review of the clinician involved in the patient's care was completed on 9/27/2010. Peer Review of the LPN involved in the patient's care was initiated on 1/6/12. No other clinical staff were identified as involved in this case.

Status: In Progress

Recommendation 6. We recommended that the Medical Center Director ensure that problematic staff relationships are appropriately addressed and resolved.

Concur

Target Completion Date: 4/2/2012

Facility's Response:

The following actions were taken to improve interpersonal relationships among staff:

1. The Equal Employment Opportunity (EEO) Manager provided on site team building training to staff at the Salina CBOC.
2. The Employee Assistant Consultants (EMPAC) Group provided additional on site team building training.
3. Additional staff (one RN, one LPN and one Physician) was hired for the CBOC.

An assessment of interpersonal relationships will be conducted by a group from outside the Robert J. Dole VA Medical Center.

Status: In progress

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Dorothy Duncan, RN, MHA Project Leader Laura Tovar, LCSW Team Leader George Wesley, M.D. Physician Consultant

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