Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01606-277

Combined Assessment Program Review of the St. Louis VA Medical Center St. Louis, Missouri

September 13, 2011

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
EN	enteral nutrition
EOC	environment of care
facility	St. Louis VA Medical Center
FY	fiscal year
IC	infection control
MH	mental health
OIG	Office of Inspector General
PR	peer review
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, MO

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 June 13, 2011.

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

- Medication Management

Recommendations: We made recommendations in the following seven activities:

Quality Management: Analyze aggregate data, document discussions, and make recommendations based on the analysis. Require written requests for peer review extensions to be submitted to the facility Director and approved in writing prior to the 120-day deadline.

Physician Credentialing and Privileging: Ensure physicians complete the required training regarding medications used for moderate sedation.

Coordination of Care: Update facility advance directive policy to define staff responsibilities, and ensure all components of notification and screening are provided and documented in the medical record.

Enteral Nutrition Safety: Revise facility enteral nutrition and infection control policies, and monitor compliance with the updated policies. Ensure enteral nutrition documentation includes all required elements. Provide written instructions to patients discharged with enteral nutrition, and document receipt.

Registered Nurse Competencies: Consistently follow the established process for competency assessment and validation, identify competencies that are consistent with individual nursing assignments, ensure competency validation documentation is complete, and specify the methods used to assess and validate competency.

Management of Workplace Violence: Write and implement a comprehensive workplace violence policy that includes a training plan.

Environment of Care: Ensure designated staff complete annual N95 respirator fit testing, and monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

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

The review covered facility operations for FY 2010 and FY 2011 through June 17, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the St. Louis VA Medical*

Center, St. Louis, Missouri, Report No. 08-00400-190, August 26, 2008). (See Appendix B for further details.) The facility had corrected 18 of the 20 findings from our previous review.

During this review, we also presented crime awareness briefings for 38 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Results

Review Activities With Recommendations

QM

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

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Data Analysis. VHA requires that facilities review and analyze QM data, take actions based on the analysis, and track actions to completion.[1] Committees responsible for oversight of moderate sedation, mortality review, and resuscitation events did not analyze aggregate QM data. Although committee minutes documented discussion of individual patient events with aggregate data attached to the minutes, there was no documentation of review, discussion, or analysis of the aggregate data. The critical analysis of aggregate moderate sedation data was a repeat finding from the previous CAP review.

PR. VHA requires that PRs be completed within 120 days and that any needed extensions be requested in writing from and approved by the facility Director.[2] During FY 2011, 36 reviews exceeded the 120-day timeframe, and extensions

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
[2] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

were not properly requested. The process for written requests for extensions was implemented the week before our review. Meeting timeliness requirements for PRs was a repeat finding from the previous CAP review.

Recommendations

1. We recommended that committees responsible for moderate sedation, mortality review, and resuscitation events analyze aggregate QM data, document their discussion, and make recommendations based on the analysis.

2. We recommended that written requests for PR extensions be submitted to the facility Director and approved in writing prior to the 120-day deadline.

Physician C&P

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

We reviewed 17 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

Ongoing Professional Practice Evaluation. Facility policy requires that providers who administer moderate sedation complete training regarding medications used for sedation. None of the four physician profiles or training records we reviewed for moderate sedation competency had evidence of the locally required training.

Recommendation

3. We recommended that physicians complete the required training regarding medications used for moderate sedation.

Coordination of Care

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

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA policy. We identified the following areas that needed improvement.

AD Notification and Screening. VHA requires that patients receive written notification at each admission to a VHA facility regarding their right to accept or refuse medical

treatment, to designate a Health Care Agent, and to document their treatment preferences in an AD.[3] As part of notification, patients must be informed that VA does not discriminate based on whether or not they have an AD. We reviewed the medical records of 20 patients and found that none of the records contained evidence of all required components of written notification.

Additionally, VHA requires that staff screen patients at each admission to a VHA facility to determine whether they have an AD and document the screening in the medical record.[4] Facility staff did not document all the components of AD screening for 8 of the 20 patients whose medical records we reviewed.

Facility Policy. VHA requires that the facility identify the staff responsible for providing AD notification.[5] Facility policy did not designate the staff responsible for providing AD notification.

Recommendations

4. We recommended that processes be strengthened to ensure that all components of written AD notification and screening are provided to patients and documented in the medical record.

5. We recommended that facility policy be updated to include identification of the staff responsible for providing AD notification.

EN Safety

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

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

Policy. VHA requires that health care staff follow specific procedures relating to EN.[6] Three of four local policies had not been updated and were inconsistent with current VHA policy. For example, VHA requires x-ray confirmation of

[3] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives,* July 2, 2009.
[4] VHA Handbook 1004.02.
[5] VHA Handbook 1004.02.
[6] VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

nasogastric tube placement prior to using the tube for EN feedings. However, one local policy required x-ray verification of tube placement only if certain bedside tests did not confirm proper tube placement.

VHA also requires that facility IC policy address EN.[7] We reviewed facility IC policy and determined that it did not address IC expectations for EN, such as swabbing the tops of EN cans with alcohol wipes before pouring contents into feeding bags.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.[8] We reviewed the medical records of 10 EN patients and found that 7 records did not contain all required information, such as x-ray verification of nasogastric tube placement prior to using the tube for EN feedings, checking gastric residual, or positioning the patient.

EN Patient Education. VHA requires that patients receive instructions regarding diet upon discharge.[9] In addition, The Joint Commission requires that clinicians provide patients with written discharge instructions and document that the instructions were received. We reviewed the medical records of three EN patients and found that two records did not contain documentation that EN discharge instructions were provided**.**

Recommendations

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

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

8. We recommended that processes be strengthened to ensure that written instructions are provided to patients discharged with EN and that receipt is documented.

[7] VHA Handbook 1109.05.
[8] VHA Handbook 1109.05.
[9] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

RN Competencies

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

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

Facility Competency Validation Process. The Joint Commission requires that clinical staff are deemed competent to perform their job responsibilities and that the facility takes action when staff competency does not meet expectations. A competency validation policy or process is required for staff who provide patient care, treatment, or services. Although the facility had implemented a competency validation process in the month prior to our review, the process was not evident for 9 of the 12 RNs.

Competency Validation Documentation. The Joint Commission requires that nursing personnel are competent to function in their assignments. Core competencies, such as medication administration, are skills required for all RNs. Unit/position competencies are specific to a particular area of patient care, such as an intensive care unit. Ten of the 12 RN competency folders had incomplete or missing unit-specific competencies for FY 2010.

Competency Validation Methods. The Joint Commission requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. In 9 of the 12 competency folders, we found that validation methods were not specified for the skills being assessed and validated.

Recommendations

9. We recommended that the established process for initial and ongoing RN competency assessment and validation be consistently followed.

10. We recommended that managers identify unit/position-specific RN competencies for all patient care areas that are consistent with the individual's nursing assignment.

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

12. We recommended that unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

Management of Workplace Violence

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

We interviewed managers and reviewed applicable documents. We identified the following area that needed improvement.

Facility Policy. The Occupational Safety and Health Administration requires facilities to have a comprehensive written workplace violence policy. The facility did not have a policy, training plan, or process in place that addressed managing violent or disruptive behavior.

Recommendation

13. We recommended that a comprehensive workplace violence policy that includes a training plan be written and implemented.

EOC

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

We inspected inpatient units (medical, surgical, telemetry, intensive care, progressive care, MH, rehabilitation, spinal cord injury, and community living center), the emergency department, the same day surgery/post-anesthesia care unit, and outpatient clinics. The facility maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

IC. If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 25 employee training records and determined that 4 designated employees did not have the required annual fit testing.

Recommendation

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

Review Activity Without Recommendations

Medication Management

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

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

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 17–22 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[10]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	15	
Community Based Outpatient Clinics	Belleville, IL St. Louis, MO St. Charles, MO	
Veteran Population in Catchment Area	239,016	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	285	
• **Community Living Center/Nursing Home Care Unit**	71	
• **Other**	0	
Medical School Affiliation(s)	Saint Louis University School of Medicine Washington University School of Medicine	
• **Number of Residents**	126.5	
	FY 2011 (through April 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$357	$367
• **Medical Care Expenditures**	$211	$367
Total Medical Care Full-Time Employee Equivalents	2,429	2,330.1
Workload:		
• **Number of Station Level Unique Patients**	47,371	47,203
• **Inpatient Days of Care:**		
o **Acute Care**	47,723	45,535
o **Community Living Center/Nursing Home Care Unit**	12,117	11,552
Hospital Discharges	6,218	6,089
Total Average Daily Census (including all bed types)	282.75	269.28
Cumulative Occupancy Rate (in percent)	79.42	75.64
Outpatient Visits	356,407	376,468

[10] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Use performance data in the C&P process, in accordance with VHA policy.	Standardized Ongoing Professional Practice Monitor Reports are in place. The Medical Staff Improvement Plan is updated annually.	Y	N
2. Meet VHA requirements for cardiopulmonary resuscitation training for all clinically active staff.	Facility policy was revised to include all clinically active staff. The Code K Committee and service chiefs monitor compliance.	Y	N
3. Privilege contracted providers only for the time they are associated with the facility.	Contracted providers are privileged only for the period of their appointment (January to December each year).	Y	N
4. Meet VHA timeliness requirements for PRs.	PR timeliness is monitored by the Risk Manager; reminders are sent to providers and service chiefs. Additional PR Committee meetings are held. Screening criteria was developed and approved to decrease the number of PRs sent to committee.	N	Y (see pages 2–3)
5. Meet VHA requirements for inter-rater reliability reviews for the utilization management program.	Inter-rater reliability is monitored by the utilization management coordinator. Testing is current.	Y	N
6. Meet VHA requirements for copying and pasting text into the electronic medical record.	Chief Health Information Management established facility policy governing copying and pasting. A process was established for staff to report copy and paste occurrences. Medical records are monitored.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
7. Critically analyze, trend, and monitor aggregate moderate sedation data.	Moderate sedation is tracked and analyzed by the Invasive Procedure Committee. In 2011, oversight responsibility was changed to the Medical Staff Performance Improvement Committee.	N	Y (see pages 2–3)
8. Complete operative reports in accordance with VHA policy.	The Chief and Assistant Chief of Surgery Service continue to monitor completion of operative reports. Compliance is currently at 99.4 percent.	Y	N
9. Address patient flow in temporary bed and overflow locations.	Policy was developed and implemented. Patient flow is reviewed daily as a part of morning report. Morning and afternoon bed huddles are held to maximize patient flow.	Y	N
EOC			
10. Correct IC vulnerabilities.	Engineering checked the length of emergency call system cords in all patient bathrooms to ensure they are accessible from the floor and made of appropriate material. Engineering identified all patient rooms with overbed lights that used tape as pull cords. All were replaced with appropriate pull cords. Monitoring is performed on EOC rounds. Engineering contracted to install a centrally monitored patient care refrigerator and freezer system. Supervisors and managers were educated on manual monitoring. Ongoing monthly audits are conducted. Full implementation of the electronic monitoring	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
	system is due by September 30, 2011. The EOC Committee will oversee and monitor the project. Engineering completed a project to ensure proper temperature and humidity control in medication storage rooms. Ongoing monitoring of patient care equipment, furniture, and storage areas is performed on EOC rounds.		
11. Correct safety vulnerabilities.	Engineering replaced ceiling tiles and grids in locked psychiatric unit day rooms with solid ceilings. Ceiling panels in the locked psychiatric unit main hallways have plastic tabs to prevent access. Engineering replaced the shower control fixture in the women's shower on one of the locked psychiatric units with an institutional fixture. Engineering replaced the nursing station door on a locked psychiatric unit with a 'Dutch Door' to reduce the risk of unauthorized entry. It was not feasible to correct the slope issue in individual showers. These showers are no longer used, and patients use the unit's shower room. Ongoing monitoring of storage of medication, cleaning solutions, oxygen tanks, and	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
	equipment and emergency crash cart inspections are performed on EOC rounds.		
12. Correct patient privacy vulnerabilities.	Privacy rounds frequency was increased. VA police round actively after business hours. White marker boards are no longer visible from the hallway.	Y	N
13. Evaluate inpatient MH overflow, ensure proper unit designation, and complete environmental planning to assure patient safety.	In June 2008, MH leadership reviewed admission practice patterns and developed criteria based on age and behaviors. In March 2010, a third acute MH unit was opened, reducing placement of general psychiatry patients on the geropsychiatry ward. Two general psychiatry units were renovated to enhance safety. The third unit is to be renovated prior to September 30, 2011.	Y	N
Pharmacy Operations			
14. Conduct controlled substances inspections in accordance with VHA policy.	The overall inspection compliance rate for FY 2010 was 99 percent. The overall compliance rate for FY 2011 is 100 percent.	Y	N
15. Correct all indentified EOC findings within the pharmacy at the Jefferson Barracks division.	Engineering replaced soiled ceiling tiles and sealed pharmacy ceiling penetrations. Ceiling vents and the identified unit were cleaned and repaired. Engineering reviewed the pharmacy floor finding; replacing the floor is unfeasible. A new building project will expand pharmacy space and eliminate the issue. Partial funding is expected in FY 2012 with full funding expected in FY 2013.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
16. Correct the identified privacy concerns at the Jefferson Barracks division.	A renovated room is used as a pharmacy patient waiting space, allowing separation of the combined waiting/consultation areas. Renovations will create additional consultation space. Three white noise generators were purchased and installed in the consultation and waiting rooms.	Y	N
Follow-Up on Background Investigations and Security Clearances			
17. Comply with VHA employment screening requirements.	The Human Resource manager developed a screening checklist, and it has been applied to all employees. The most recent revision occurred on May 27, 2010.	Y	N
Follow-Up on Moderate Sedation Practices			
18. Document cardiopulmonary resuscitation training in the electronic training record, as required by facility policy.	Training is recorded in the Talent Management System and tracked by the credentialing supervisor.	Y	N
19. Document current training in airway management and cardiac arrhythmias for all providers privileged to administer moderate sedation.	Documentation of training to administer moderate sedation is reviewed by the Professional Standards Board.	Y	N
20. Privilege providers who administer moderate sedation in accordance with VHA policy.	Moderate sedation privilege was standardized. A list of all providers with moderate sedation privileges is maintained by the credentialing supervisor and published to the services.	Y	N

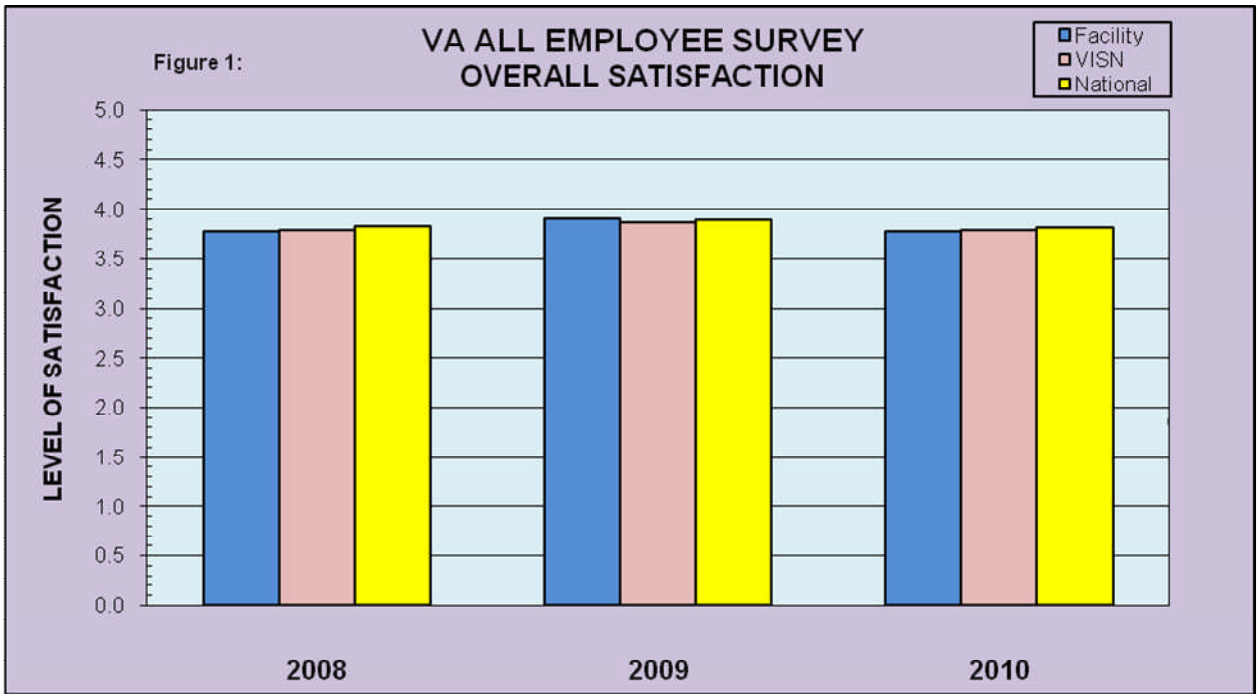
VHA Satisfaction Surveys

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

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	48.4	43.6	45.3	43.2	49.4	50.5	45.8	49.0
VISN	59.0	56.0	56.9	55.2	53.5	52.9	51.6	52.5
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. 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[11] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	12.67	6.61	15.09	19.84	22.81	16.45
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[11] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens 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 in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 18, 2011

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the St. Louis VA Medical Center, St. Louis, MO**

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

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

I have reviewed the findings and recommendations and concur. Our actions to the recommendations are attached.

James R. Floyd, FACHE

Network Director VISN 15

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 18, 2011

From: Director, St. Louis VA Medical Center (657/00)

Subject: **CAP Review of the St. Louis VA Medical Center, St. Louis, MO**

To: VISN Director (10N15)

1. I concur with the findings and recommendations presented in the St Louis VA Medical Center OIG Report. Implementation plans and target completion dates for each recommendation are included in the following pages.

2. The Medical Center benefited from the thorough review of the operations, systems, and processes. It revalidated the quality and safe patient care that is provided to our Veterans.

3. Questions or further comments regarding this response can be directed to me.

Rimaann O. Nelson RN MPH/HAS
Medical Center Director

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that committees responsible for moderate sedation, mortality review, and resuscitation events analyze aggregate QM data, document their discussion, and make recommendations based on the analysis.

Concur

Target date for completion: December 31, 2011

The Chief, Quality Management will train chairs and recorders of committees responsible for review of QM data to ensure the documentation of discussion, analysis and recommendations based on the analysis. Minutes will be reviewed for compliance for 6 months by the Chief, Quality Management. Audit results will be reported to Quality Executive Board.

Recommendation 2. We recommended that written requests for PR extensions be submitted to the facility Director and approved in writing prior to the 120-day deadline.

Concur

Target date for completion: June 30, 2011

Risk Manager will continue to obtain written request for Peer Review extension from the Medical Center Director prior to the 120 day deadline. Number of extensions requested and granted prior to the 120 day deadline will be included in quarterly peer review report to the Medical Executive Board.

Recommendation 3. We recommended that physicians complete the required training regarding medications used for moderate sedation.

Concur

Target date for completion: September 30, 2011

As required by Medical Center Policy, physicians have completed required training regarding medication use for moderate sedation. This training was not consistently documented in the physician file. Training will be recorded in Talent Management System (TMS). Incumbents with moderation sedation privileges will record training in TMS by September 30, 2011.

Recommendation 4. We recommended that processes be strengthened to ensure that all components of written AD notification and screening are provided to patients and documented in the medical record.

Concur

Target date for completion: September 30, 2011

The Chief, Social Work will ensure staff received education of all components of written AD notification and screening procedures. Individuals with a role in the process will have training specific to the documentation requirements in the medical record. Chief, Social Work will audit medical records for compliance. Chief, Social Work will report compliance data to Clinical Executive Board.

Recommendation 5. We recommended that facility policy be updated to include identification of the staff responsible for providing AD notification.

Concur

Target date for completion: September 30, 2011

The Chief, Social Work will revise medical center policy to include identification of staff responsible for providing AD notification.

Recommendation 6. We recommended that facility policies related to EN be updated to be consistent with VHA policy, that facility IC policy be revised to include EN IC expectations, and that compliance with the updated policies be monitored.

Concur

Target date for completion: September 30, 2011

The Chief, Clinical Nutrition will lead an inter-disciplinary team to updated medical center policies related to EN to be consistent with VHA policy. Infection Prevention practices were reviewed and incorporated in the updated policies. An observation checklist was developed to monitor compliance with the revised policy. Chief, Clinical Nutrition will report compliance data to Clinical Executive Board.

Recommendation 7. We recommended that processes be strengthened to ensure that EN documentation includes all required elements.

Concur

Target date for completion: September 30, 2011

The inter-disciplinary team reviewed and revised documentation templates associated with EN to include all required elements. Staff were trained on the new templates prior to use. Chief, Clinical Nutrition will conduct documentation audits to monitor

compliance. Chief, Clinical Nutrition will report compliance data to Clinical Executive Board.

Recommendation 8. We recommended that processes be strengthened to ensure that written instructions are provided to patients discharged with EN and that receipt is documented.

Concur

Target date for completion: September 30, 2011

The inter-disciplinary team reviewed and revised written discharge instruction EN materials. Provision of EN written instructions will be documented in the medical record. Chief, Clinical Nutrition will conduct documentation audits to monitor compliance. Chief, Clinical Nutrition will report compliance data to Clinical Executive Board.

Recommendation 9. We recommended that the established process for initial and ongoing RN competency assessment and validation be consistently followed.

Concur

Target date for completion: September 30, 2011

The RN competency assessment process was established and fully implemented May 2011. This process included revision of medical center policy "Competency and Training Verification Program," education of supervisors and staff, standardized forms, standardized layout of six part competency folder, with physical review of competency folders and content audit. Associate Chief Nurse for Education will report compliance data to Clinical Executive Board.

Recommendation 10. We recommended that managers identify unit/position-specific RN competencies for all patient care areas that are consistent with the individual's nursing assignment.

Concur

Target date for completion: August 31, 2011

The Nurse Managers in collaboration with Nursing Instructors determined on-going competencies based on high risk, low volume, problem prone processes, procedures, and equipment, data, and identified needs from supervisors and staff. The on-going competencies are individualized to each unit/area of nursing practice.

Recommendation 11. We recommended that processes be strengthened to ensure that competency validation documentation is complete.

Concur

Target date for completion: August 31, 2011

Medical Center Memorandum "Competency & Training Verification Program" identifies a standardized method to document competency verification. Training has been provided for each Nurse Manager on the standardized method for documenting competency verification. The competency folders will be audited for compliance by the Associate Nurse Executive for Education and reported to the Clinical Executive Board.

Recommendation 12. We recommended that unit/position-specific competency validation documentation specify the methods used to assess and validate competency.

Concur

Target date for completion: August 31, 2011

The method used to assess and validate competency was added for each unit/position specific competency. Associate Chief Nurse for Education will report compliance data to Clinical Executive Board.

Recommendation 13. We recommended that a comprehensive workplace violence policy that includes a training plan be written and implemented.

Concur

Target date for completion: September 30, 2011

Associate Chief of Staff for Mental Health Service developed a comprehensive workplace violence policy for medical center. A training plan was developed in accordance with the policy. Compliance will be monitor and reported to the Medical Executive Board.

Recommendation 14. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: September 30, 2011

The Safety Manager will ensure that N95 respirator fit testing is completed during new employee orientation and annually thereafter. The Safety Manager will monitor and reported compliance to the Administrative Executive Board through the Environment of Care Committee.

OIG Contact and Staff Acknowledgments

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