Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Polytrauma Care, Environmental, and Safety Issues Minneapolis VA Medical Center Minneapolis, Minnesota

Report No. 06-03671-120 **April 25, 2007**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General received a Congressional request to review the care of a soldier who received rehabilitative services at the Minneapolis VA Medical Center. During a television network interview, the soldier's family alleged that there was substandard care and negligence at the medical center.

The soldier was on active duty with the United States Army National Guard when he sustained a traumatic brain injury in Iraq on December 4, 2005. He was admitted to the medical center on January 12, 2006, for acute rehabilitation services and was discharged on May 24. We contacted the family to collect information regarding their experiences at the medical center. The family also alleged that there were breaches in patient confidentiality, poor communication with the interdisciplinary treatment team, missed episodes of rehabilitative therapy, and rodent infestation in the medical center.

We did not substantiate problems with rehabilitative therapies. We examined the medical center's review of this patient's therapy appointments and found that the patient had 352 scheduled therapy appointments and 21 cancellations, 16 of which were due to medical procedures or changes in the patient's medical status. On November 20, 2006, we conducted an unannounced inspection of the medical center. We interviewed staff members, reviewed therapy schedules for traumatic brain injury patients, and reviewed patient satisfaction survey data. VA policy specifies core staffing levels for polytrauma units; we found that the medical center met or exceeded these standards.

We substantiated that patients and families do not routinely attend interdisciplinary treatment team conferences; however, patients and families are involved in treatment planning processes. We did not substantiate allegations that there were injuries, neglect, or substandard care. We did find documentation by clinicians from multiple disciplines who provided care to the patient during the evening of the first night of his admission. We substantiated breaches of confidentiality and patient privacy in various areas of the medical center. In the patient rooms on the acute rehabilitation unit, we found sensitive patient information on clipboards. We also found a coffee maker located in Radiology's Ultrasound Section examination room as stated in the allegation; this problem was addressed while we were onsite. We substantiated that, despite past improvement and ongoing efforts at amelioration, rodents remain a problem.

We recommended that management correct violations in patient confidentiality and privacy in accordance with Veterans Health Administration policy. Management submitted appropriate 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: Veterans Integrated Service Network Director (10N23)

SUBJECT: Healthcare Inspection – Quality of Polytrauma Care, Environmental, and Safety Issues, Minneapolis VA Medical Center, Minneapolis, Minnesota

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) received a congressional inquiry to review the care of a soldier who received rehabilitative services at the Minneapolis VA Medical Center (the medical center). During a television network interview, the soldier's family alleged that there was substandard care and negligence at the medical center. The purpose of our inspection was to determine the validity of these allegations.

Background

The medical center, part of Veterans Integrated Service Network (VISN) 23, includes one of the Veterans Health Administration's (VHA) four Polytrauma Units created in response to the rehabilitation needs of wounded soldiers from Operation Iraqi Freedom (OIF).

We received a congressional request to review the care rendered to a returning OIF soldier at the medical center. A television network segment which aired on August 3, 2006, contained video images of the soldier receiving care at the medical center. In the course of televised interviews, the soldier's wife and mother alleged that the soldier was left alone in a room with a tracheostomy[1] mask off and with the room door closed. The family also contended that the soldier did not receive scheduled rehabilitative therapies due to lack of staffing.

The soldier was on active duty with the United States Army National Guard. He had been injured by an improvised explosive device in Iraq on December 4, 2005, sustaining a severe penetrating traumatic brain injury (TBI) with residual cognitive and visual deficits. He was admitted to the medical center on January 12, 2006, for acute

[1] Surgical construction of an opening in the trachea for the insertion of a catheter or tube to facilitate breathing.

rehabilitation services. On May 24 he was discharged from the VA medical center in Minneapolis with plans for a May 25 admission to Bethesda Naval Hospital, Bethesda, MD, for cranioplasty surgery (procedure to correct skull defect after TBI). This procedure was performed on May 30, and he remained there until his acceptance to Casa Colina Centers for Rehabilitation, Pomona, CA, on June 20. He continues in rehabilitation at Casa Colina Centers for Rehabilitation as of the date of our report.

In addition to the problems described in the television interview, the family alleged that there were breaches in patient confidentiality, a lack of communication between the treatment team and the family, missed therapy treatments, and rodent infestation in the medical center.

Scope and Methodology

We interviewed the patient's wife and mother to collect information regarding their experiences at the medical center. On November 20–21, 2006, we conducted an unannounced inspection of the medical center. We interviewed VISN and medical center management, staff, and contractors, and inspected the Polytrauma Unit and related therapeutic areas. We also evaluated the environment of care in various areas of the medical center and examined records pertaining to staff education and scheduled therapies for Polytrauma Unit patients. Finally, we reviewed recent patient/family satisfaction surveys, medical center policies, committee minutes, and pest contractor reports.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Therapy Issues

Adequacy of Staffing and Therapies. We did not substantiate problems with therapies. The patient's family stated that on multiple occasions he was unable to participate in rehabilitative therapies because nursing support was inadequate to assist him in preparing to participate. Family members reported that they had to be present to ensure the patient was ready for therapy.

Medical center managers conducted a review of the patient's therapy appointments during his hospitalization; they found that he had 352 scheduled therapy appointments and 21 cancellations. Managers characterized missed appointments as follows: 16 cancellations due to medical procedures or changes in the patient's medical status, 3 cancellations due to nursing care, 1 cancellation due to an extended time in another therapy, and 1 due to a scheduling error.

To assess possible problems with the provision of current treatments, we made an unannounced visit to the Acute Rehabilitation Unit (Ward 4JT) at 8:00 a.m. on Monday, November 20, 2006. At that time the unit had 13 patients, 7 of whom were polytrauma patients. Four of the seven patients were not in their rooms during the time of our inspection. Among the three polytrauma patients who were in their rooms, one patient had a sign posted on the door requesting not to be disturbed; this patient did not have therapy scheduled until 10:00 a.m. A second patient was receiving bedside nursing care, with therapy scheduled to begin at 9:00 a.m. The third patient was newly admitted and receiving a bedside evaluation.

We reviewed the previous week's therapy schedules for polytrauma patients. Therapy schedules varied and were individualized to each patient's tolerance level and treatment plan. Therapies were provided for each of six patients during the weekend. (The newly admitted patient was not yet physically able to begin therapy.) The following table depicts the number of weekend therapies scheduled for these patients.

Number of Therapy Sessions							
Day	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5	Patient #6	Patient #7
Saturday	4	4	3	3	2	3	0 new admission
Sunday	2	1	1	1	0	1	0 new admission

VHA policy specifies core staffing levels for polytrauma units. We found that the medical center has 12 polytrauma beds and was in compliance with VHA policy. The following table delineates staffing levels for the various disciplines involved in polytrauma care.

Discipline	VHA Core Staffing Recommendation *per 6 polytrauma beds*	Medical Center Staffing *per 12 polytrauma beds*
Registered Nurses *(1.0 must be Certified Rehabilitation Registered Nurse [CRRN])*	5.5	17 *(3.0 CRRNs)*
Licensed Practical Nurse and/or Certified Nursing Assistant	4.4	16.8
Speech-Language Pathologist	1.0	2.0
Physical Therapist	1.0	2.5
Occupational Therapist	1.0	2.5
Recreational Therapist	0.5	2.5

Therapists reported that the nursing staff usually has patients ready for therapy, delays are infrequent, and staffing was adequate to care for patients. Managers informed us that therapy staffing levels are similar to that at the other three Polytrauma Rehabilitation Centers. We observed therapies being conducted in patient rooms and in clinic areas. Therapists stated that family members are encouraged to attend therapy sessions.

We interviewed the Chief Nurse and the Nurse Manager for the Acute Rehabilitation Unit and were told that the current assigned staffing levels of nursing employees were adequate. Managers stated that staffing levels are compared to independent benchmarking data, and that staffing exceeds private sector practices. Also of note, three of the registered nurses assigned to the Acute Rehabilitation Unit had achieved certification in rehabilitation care.

Issue 2: Family Communication, Education, and Patient Satisfaction

Treatment Plan Process. We substantiated that this patient and family did not attend, and that other patients and families do not usually attend, Interdisciplinary Treatment Team conferences. However, patients and families are routinely involved in the treatment planning process; that was the case for the patient described in this report.

The patient's wife and mother said that they were never directly involved with the treatment plan and would be notified of its progress only after they complained. We were informed during our interviews that the Interdisciplinary Treatment Team's goals,

comments, and other issues are described for the patient and family primarily by the Social Work Case Manager. Each member of the team then reinforces the weekly goals during their care/therapy sessions with the patient. If team goals are not acceptable to the patient or family, a discussion is to occur with the appropriate discipline. Conflicts are presented to the team for reassessment and/or modification of the treatment plan. We discussed with the Chief of Physical Medicine and Rehabilitation (PMR) Service the possibility of allowing patients and families to attend Interdisciplinary Treatment Team conferences. The chief agreed to consider this option in selected cases.

Family meetings are scheduled at various times during a patient's hospitalization but specifically prior to discharge. At any time a patient or family member can request a meeting with the entire team to discuss the plan of care, treatment goals, and functional gains. Depending on the availability of the entire team and the urgency of the issue, family meetings with specific members of the team may be arranged to allow prompt discussion of the patient/family questions or concerns. We found evidence that family meetings occurred. For the individual patient whose care prompted this review, a first family meeting was conducted on January 27 and an additional meeting was held on February 28. Documentation in the medical record shows that a family meeting was scheduled for May 15, but that this meeting was canceled. The patient's wife was in agreement with the cancellation and expressed that it was not necessary to reschedule a family meeting prior to the patient's discharge on May 24. Documentation also reveals that the patient's wife described family meetings as being futile because issues were not being resolved.

Communication. Family members told us that they were given a communication book to write their observations and questions. They said that in February, when they observed the patient writing, they documented this progress in the communication book because they felt it was a significant functional gain. According to the family, the patient's physician was unaware of this accomplishment until April. The communication book is not retained after discharge; therefore we were unable to fully evaluate this issue.

We reviewed the weekly rehabilitation interdisciplinary treatment plan documentation. On February 14, it was documented in an Interdisciplinary Treatment Plan progress note by a Social Work Case Manger that the patient could draw squares and circles. This functional gain was acknowledged and countersigned by the patient's physician on February 15. On March 14, it was documented by a Social Work Case Manger in an Interdisciplinary Treatment Plan progress note that the patient was writing letters and words, and this note was countersigned by the patient's physician on March 17.

The family also informed us that the Social Work Case Manager originally assigned did not adequately explain processes, policies, or procedures. Family members stated that on one occasion they were given papers and instructed to sign them without explanation. They said that they refused to sign the papers and later discovered that the paperwork was related to the patient's military medical discharge and that if the paperwork had been

signed the patient's military medical benefits would have been adversely affected. Medical center managers informed us that they acknowledged the complaints of the family; in response, a new Social Work Case Manager was assigned.

We reviewed patient satisfaction data from the VHA Survey of Healthcare Experiences of Patients. We also reviewed data collected by the medical center's acute rehabilitation unit from 27 patient satisfaction surveys conducted during April–September 2006. Fifteen of the 27 patients had diagnoses of cerebral vascular accident (stroke) and 12 patients had diagnoses of TBI. The TBI patient data showed that 83 percent (of the 12 patients) were satisfied with their care and 66 percent felt that the people who worked with them helped them achieve their goals.

Issue 3: Environment of Care – Patient Injuries, Patient Privacy, and Pests

Safety and Neglect. We did not substantiate that there were injuries, neglect, or substandard care.

The family informed us that the patient had been injured with an assistive transferring device on two occasions, once being struck on the head and once scraped on the foot. The family alleged that the clinical nurse manager was aware of both incidents. We interviewed managers and staff regarding the alleged incidents. No one recalled the incidents. In addition, we reviewed all related incident reports and found no documentation to support this allegation.

During the television network broadcast in August 2006 and in our telephone interview, the family expressed concerns about the first night of their arrival to the medical center. The family stated that they went out for dinner and returned to find the patient in a darkened room alone, with a wet gown, without medications or food, and with his tracheostomy mask (used to assist breathing) off. After that incident, they stated that they never left the patient alone.

We reviewed the medical records for January 12. The patient's arrival time on the unit was 2:30 p.m. At 4:27 p.m., Ear, Nose, and Throat Service staff provided treatment for the patient's tracheostomy. At 5:41 p.m., there is documentation in a physician order stating the patient's condition was stable. At 7:21 p.m., there is documentation showing the patient's heart rhythm; and during the hours of 6:00 p.m., 9:00 p.m., and 12:00 a.m. there are vital signs recorded in the medical record. There is also documentation at 9:00 p.m. that tube feedings were being started. At 10:09 p.m., the respiratory therapist documented two evening visits.

Privacy. We substantiated breaches of confidentiality and patient privacy in various areas of the medical center.

VHA policy states that the privacy of patient information be preserved and not be accessible to unauthorized personnel. In addition, auditory privacy must be maintained when employees are discussing sensitive patient information. We observed three open windows in the Outpatient Pharmacy and Cashier area where sensitive patient health and personal identification information could be overheard by those sitting in the waiting area.

In the patient rooms on the Acute Rehabilitation Unit, we found personal health information on clipboards. The clipboards were covered with an occlusive plastic page; however, the information was unsecured and accessible to anyone who entered the room. We also noted that the patient's Functional Independence Measure™ progress reports were taped to bedside cabinets in open view. Personal health information was also noted on this report.

The family also alleged that there was a lack of privacy and confidentiality in the Radiology's Ultrasound Section. We were told that staff members were in and out of the ultrasound room while the patient was being tested. The staff members were reportedly getting coffee from a coffeemaker located near the head of the examination bed. The family also stated that the patient was partially uncovered and that other patients who were in the same area could hear discussion of confidential information about his condition.

We inspected the Ultrasound Section rooms and met with staff who were knowledgeable about the physical location of procedure rooms for this area. The procedure room where the patient was examined had three examination beds separated by privacy curtains, with two doorways to enter the room. One of the three beds was located directly in front of the first section's doorway; therefore, those who entered would see the patient in the first bed, where this patient was during testing. Documentation shows that there were also two other patients in this room on the day and at the time this patient was examined. Ultrasound staff acknowledged that patient privacy was very challenging considering the configuration and high volume of use of this room. They told us that they did not allow family members in the rooms, pulled privacy curtains around each patient, and spoke quietly to protect confidential patient information, particularly when other patients were in the room. During this inspection, there was only one patient in the room, and no violations of privacy or confidentiality were observed.

At the head of the first bed, where the patient was examined, there was a small cabinet hidden by a curtain in the corner that had a coffeemaker and other food items on top and in a drawer. Specialized medical equipment was also stored in this corner. Staff informed us that they do use this area to prepare coffee. Management took immediate action to remove the coffeemaker and all food items from this area while we were onsite.

Rodent Activity. We substantiated that there is an active rodent problem in the medical center.

The family alleged that the facility was mice infested, especially in the first floor atrium areas where trees and planters were abundant. Staff also informed us that they observed patients feeding mice in the outdoor smoking area, and propping exit doors open during evening hours, thus allowing access for mice to enter the medical center. We completed inspections in various areas of the hospital including the first floor Canteen, Food and Nutrition Service areas, and several patient care areas. We did not see mice during our inspection. We did see numerous rodent catching devices throughout the building, which also included the atrium planters. A review of the pest control logs from January 1 through November 17, 2006, revealed 92 entries related to rodent sightings or related activity. We interviewed food service staff who informed us that they had not seen mice in some time and noticed an improvement after the medical center acquired a new pest control contractor. The current pest control contractor, which began work in September or October 2005, is available 5 days a week in various areas of the medical center. However, we found rodent excrement in the Canteen food can storage room on a floor beside a metal rodent catching device and snap traps. During our inspection of patient rooms, we found a mouse hole with a rodent catching device nearby. We reviewed the pest control reports and found that the hole had been identified on November 1, 2006; however, it had not been repaired at the time of our inspection.

Conclusion

We did not substantiate problems with rehabilitation therapeutic services and found no evidence of inadequate staffing. The medical center is following VHA core staffing recommendations for Polytrauma Rehabilitation Centers. Therapists we interviewed informed us that nursing staff have patients ready for scheduled therapies and that delays are infrequent.

We substantiated that patients and family do not routinely attend Interdisciplinary Treatment Team conferences; however, patients and family are involved in the treatment planning process. There is a process in place for family involvement with the Interdisciplinary Treatment Team.

We could not substantiate or refute that there were injuries, neglect, or substandard care. We interviewed managers and staff regarding the alleged incidents and reviewed medical center incident reports pertaining to the patient. We reviewed the medical record and found documentation by clinicians of multiple disciplines who provided care during the evening of the first night of the patient's admission.

We did substantiate breaches in patient privacy and confidentiality. We found individually-identifiable health information unsecured in patient rooms and patient health information could be overheard by others in a waiting room adjacent to the Outpatient

Pharmacy and Cashier area. VHA policy requires that patient health information be protected from unauthorized access. Additionally, we found that staff were using a patient examination room to prepare coffee. This was corrected while we were onsite.

We substantiated that the medical center is actively combating rodent activity. We inspected the facility, reviewed pest control logs, and interviewed the pest control contractor. We concluded that the medical center had an aggressive pest control program.

Recommendation

Recommendation: We recommended that the VISN Director ensures that the Medical Center Director corrects violations in patient confidentiality and privacy in accordance with VHA Policy.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 10–12 for the full text of their comments.) In response to our OIG Inspection Draft Report, they also provided a VA Midwest Health Care Network (VISN 23), Minneapolis VA Medical Center, VHA Issue Brief, which includes a summary of the case and very detailed information on the medical center's Integrated Pest Control Management program. (See Appendix C, pages 13–15 for the full text of this document.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 13, 2007

From: VISN Director (10N23)

Subject: **Healthcare Inspection Quality of Polytrauma Care, Environmental, and Safety Issues**

To: Director, Chicago Office of Healthcare Inspections (54CH)

1. Attached is the follow-up report to OIG addressing recommendations made from a recent inspection of the VA Medical Center, Minneapolis, Minnesota.

2. If you have questions or concerns about the report, please contact Mr. Steven P. Kleinglass, Medical Center Director, VA Medical Center, Minneapolis, Minnesota at (612) 725-2101.

ROBERT A. PETZEL, M.D.

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action(s) We recommended that the VISN Director ensures that the Medical Center Director corrects violations in patient confidentiality and privacy in accordance with VHA Policy.

Concur **Target Completion Date:** April 6, 2007

The following actions are being completed to address:

Patient confidentiality and privacy in Outpatient Pharmacy and Cashier Area: Immediate action is being taken to improve the sound proofing in this area. Action to be completed by April 6, 2007.

Patient confidentiality and privacy in Ultrasound Area in Imaging Service: Immediate action is being taken, to erect a partial wall just outside of Ultrasound Room to improve privacy of patient information. Facility will be resubmitting the Ultrasound NRM for funding in this operating year, the estimated completion date November 2007.

Unsecured Patient Health Information in Patient Rooms: Staff have been reminded on an ongoing basis to maintain in patient privacy (electronic, paper, auditory) per the Privacy Policy #IM-07A, dated January 1, 2007. To ensure compliance, the Privacy Officer attends staff meetings, authors all employee email messages, provides Annual Mandatory Reviews, instructs new employee orientation, participates in weekly Environment of Care Rounds, and conducts weekly unannounced audits, with results reported out at Medical Center Director Morning Report.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 9, 2007

From: Director, Minneapolis VA Medical Center (618/00)

Subject: **Healthcare Inspection Quality of Polytrauma Care, Environmental, and Safety Issues**

To: Director, Chicago Office of Healthcare Inspections (54CH)

1. Thank you for the opportunity to review the draft report from the OIG Healthcare Inspections team. We have reviewed the report and concur. The Recommended Improvement action concerning Patient Privacy are to be addressed by the following actions:

Patient confidentiality and privacy in Outpatient Pharmacy and Cashier Area: Immediate action is being taken to improve the sound proofing in this area. Action to be completed by April 6, 2007.

Patient confidentiality and privacy in Ultrasound Area in Imaging Service: Immediate action is being taken to erect a partial wall just outside of Ultrasound Room to improve privacy of patient information. Facility will be resubmitting the Ultrasound NRM for funding in this operating year, the estimated completion date November 2007.

Unsecured Patient Health Information in Patient Rooms: Staff have been reminded on an ongoing basis to maintain patient privacy (electronic, paper, auditory) per the Privacy Policy #IM-07A, dated January 1, 2007. To ensure compliance, the Privacy Officer attends staff meetings, authors all employee email messages, provides Annual Mandatory Reviews, instructs new employee orientation, participates in weekly Environment of Care Rounds, and conducts weekly unannounced audits, with results reported out at Medical Center Director Morning Report.

2. If you have any questions about the content of this report, please contact me at 612-725-2101.

(original signed by:)

STEVEN P. KLEINGLASS

Appendix C

VA Midwest Health Care Network (VISN 23)
Minneapolis VA Medical Center

VHA ISSUE BRIEF

Issue Title: **Draft Report of Minneapolis OIG Healthcare Inspection Report**

Date: **March 6, 2007**

Brief Statement of Issue and Status: The OIG, Office of Healthcare Inspections, received a Congressional request to review the care of a soldier who received rehabilitative services at the Minneapolis VAMC. During a network TV interview, the soldier's family alleged that there was substandard care and negligence at the VAMC. The soldier was on active duty with the US Army National Guard when he sustained a TBI in Iraq on December 4, 2005. He was admitted to the VAMC on January 12, 2006 for acute rehabilitation services and was discharged on May 24. The OIG contacted the family by telephone to collect information regarding their experiences at the VAMC. The family also alleged that there were breaches in patient confidentiality, poor communication with the interdisciplinary treatment team, missed episodes of rehabilitative therapy, and rodent infestation in the medical center. On November 20 - 21, 2006, the OIG conducted an unannounced inspection of the medical center.

In previous Issue Briefs for 10N, it was noted that the family was not satisfied with the assigned Social Work Case Manager and as the OIG reports, the VAMC managers acknowledged the complaints of the family and in response a new Social Work Case Manager was assigned.

The OIG also reviewed patient satisfaction data collected by the medical center's acute rehabilitation unit. Responses from 27 TBI patients and their families received from April through September 2006 revealed that 83% were satisfied with their care and that 66% felt that the people who worked with them helped them achieve their goals.

Findings: There were six allegations concerning this individual's patient care. Four allegations were not substantiated, and two allegations were substantiated. Of the two substantiated allegations, one recommendation improvement action was requested concerning Patient Privacy. The following actions are being completed to address:

- **Patient confidentiality and privacy in Outpatient Pharmacy and Cashier Area**: Immediate action is being taken to improve the sound proofing in this area. Action to be completed by April 6, 2007.

- **Patient confidentiality and privacy in Ultrasound Area in Imaging Service**: Immediate action is being taken, to erect a partial wall just outside of Ultrasound Room to improve privacy of patient information. Facility will be resubmitting the Ultrasound NRM for funding in this operating year, the estimated completion date November 2007.

- **Unsecured Patient Health Information in Patient Rooms**: Staff have been reminded on an ongoing basis to maintain patient privacy (electronic, paper, auditory) per the Privacy Policy #IM-07A, dated January 1, 2007. To ensure compliance, the

Appendix C

Privacy Officer attends staff meetings, authors all employee email messages, provides Annual Mandatory Reviews, instructs new employee orientation, participates in weekly Environment of Care Rounds, and conducts weekly unannounced audits, with results reported out at Medical Center Director Morning Report.

The other finding concerned a recognized rodent problem that OIG reported was being actively addressed. At the request of 10N the following list provides a timeline of the actions taken as part of VAMC Minneapolis Integrated Pest Control Management program.

- In the spring of 2005 it was determined that the Pest Control Contractor ECOLAB was not meeting pest control expectations.
- A meeting was held with ECOLAB on April 26, 2005 to identify areas needing immediate improvement.
- By late summer 2005 it was determined that a new RFQ was required and through open bid, a new Pest Control Contractor was selected and began October 1, 2005.
- On October 14th and 17th the Associate Director and Chief of EHS met with Plunkett's (company awarded the new contract) staff to discuss the importance of eliminating the rodent concern.
- A follow-up meeting was held with the Medical Center Director, Associate Director, Chief of EHS and Plunkett's staff.
- By November of 2006, a number of actions took place to all but eradicate the rodent concern.
- In less than a year's time, MVAMC had already realized an 81% reduction in rodents collected, and a 46% reduction in rodent sightings.
- At the time of this writing, the reduction is at 87% with a close to 100% reduction in reported sightings.
- Current records indicate that we have 291 monitoring devices active on the grounds with a yield of 15 mice per quarter, which would be 1 mouse for every 1746 trapping opportunities.

The origin of the patient complaint investigated by OIG in November of 2006, was directly related to Pest Control Management actions taken in February of 2006.

- On February 3 of 2006, the Canteen was closed for a comprehensive rodent clean out. To accomplish the clean out, 465 traps were set, with a yield of 3 mice when concluded on Sunday.
- The patient room (1D115) did have a mouse hole and trap, as reported on November 1st, 2006 by Plunkett's.
- Yes, the hole had not been repaired as of November 20, 2006, but it is important to note the delay in repair was recommended by the pest management contractor, Plunkett's.
- Plunkett's practice to eradicate with traps, reduces the rodent causing damage elsewhere, but more importantly by not using Rodenticide we avoid having rodents die and decay within the wall void.
- A review of Work Order database, shows that during Fiscal Years 2005 through Fiscal Year 2006, engineering completed 3 rodent related repairs and prior to Fiscal Year 2005, 16 rodent related repairs.
- Moreover, since the contract with Plunkett's, we have made well over 18 major changes to Physical Plant to bar rodent entry into the building.

Appendix C

- The main hospital buildings foot print encompasses 7.5 acres of land and has a first floor presence of approximately 300,000 square feet, with 35 exterior doors.

Reports by staff of patients feeding mice and propping exterior doors open took place in the winter of 2004. This issue was addressed with installation of a new patient smoking shelter and a video surveillance system in March of 2005.

- Security Assistants monitor all exterior doors through our video camera system, and dispatch officers when doors are propped open.

The mouse droppings identified in the Canteen Can storage room is accurate.
- Plunkett's identified this area on November 8, 2006 and the OIG team confirmed on November 20, 2006.
- The storage area in Canteen Space 1G110 was being cleaned on the date of inspection.

Finally, we recently held our annual meeting with Plunkett's leadership to discuss where we currently are and where we are going.
- It is clear that we are now in a markedly different state of Pest Control since changing Pest Control Contractors.
- To ensure we stay on track, the Associate Director will continue to conduct Environment of Care rounds weekly, to continue receive weekly pest control reports.
- Moreover, Plunkett's will be conducting an annual top to bottom pest assessment.
- Minneapolis continues its commitment to the highest level of care and access for our Veterans in the highest quality environment of care.
- Integrated Pest Management continues to be an integral part of our management approach to ensuring the highest quality environment of care.

Contact for Further Information: Steve Moynihan, PAO (612)725-2102

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN, Director Chicago Regional Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Judy Brown Paula Chapman Wachita Haywood Jerome Herbers, M.D. Jennifer Reed Leslie Rogers

Appendix E

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