Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00879-126

Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri

April 8, 2010

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 fraud and integrity awareness training 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:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www4.va.gov/oig/contacts/hotline.asp**)**

Table of Contents

Executive Summary

Introduction

During the week of February 8–12, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Harry S. Truman Memorial Veterans' Hospital (the medical center), Columbia, MO. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 254 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered seven operational activities. We made recommendations in five of the activities reviewed. For these activities, the medical center needed to ensure that:

- Staff conduct hemodialysis unit biological testing, document the action taken when results are out of range, and collect and analyze performance improvement data for the prevention of infections on the hemodialysis unit.
- Staff identified as at risk of exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.
- Locked mental health (MH) unit staff and Multidisciplinary Safety Inspection Team (MSIT) members receive environmental hazard training.
- Operating room (OR) staff utilize flash sterilization only in cases of emergency and develop an ongoing monitoring process for flash sterilization.
- Staff have manufacturers' instructions within close proximity for all reusable medical equipment (RME), wear all required personal protective equipment (PPE) while in decontamination areas, complete annual training for all pieces of RME, and have documentation of RME training and competencies.
- The designated utilization management (UM) physician completes and documents required training prior to assuming the role.
- Physicians implement and document appropriate actions when chronic renal disease (CRD) patients' hemoglobin levels exceed 12 grams per deciliter (g/dL).

- Staff complete inter-facility transfer documentation in accordance with Veterans Health Administration (VHA) policy.

The medical center complied with selected standards in the following two activities:

- Physician Credentialing and Privileging (C&P).
- Suicide Prevention Safety Plans.

This report was prepared under the direction of Dorothy Duncan, Associate Director, and Reba B. Ransom, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 13–18, for the full text of the Directors' comments.) 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

Introduction

Profile

Organization. The medical center is a medical and surgical facility located in Columbia, MO, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics located in Ft. Leonard Wood, Kirksville, Camdenton, St. James, Jefferson City, and Mexico, MO. The medical center is part of VISN 15 and serves a veteran population of about 113,000 in 44 counties in central Missouri and in 1 county in western Illinois.

Programs. The medical center provides primary care, medical, surgical, MH, rehabilitation, transitional, geriatric, and hospice services. It has 74 hospital beds, 41 community living center (CLC) beds, and 8 Residential Compensated Work Therapy Program beds.

Affiliations and Research. The medical center is affiliated with the University of Missouri School of Medicine and supports 83 medical resident positions. It also provides training for medical students and for other disciplines, including nursing, social work, and other allied health professions. In fiscal year (FY) 2009, the medical center research program had 52 active research projects with approximately $5.6 million in funding. Important areas of research included diagnostic imaging, cancer therapy, cardiovascular disease, diabetes, pulmonary care, post-traumatic stress disorder, health sciences, and development of new radiopharmaceuticals.

Resources. In FY 2009, medical care expenditures totaled $221.1 million. The FY 2010 medical care budget is $216.3 million. FY 2009 staffing was 1,121 full-time employee equivalents (FTE), including 72 physician and 366 nursing FTE.

Workload. In FY 2009, the medical center treated 31,947 unique patients and provided 17,712 inpatient days in the hospital and 13,386 inpatient days in the CLC units. The inpatient care workload totaled 3,495 discharges, and the average daily census, including CLC patients, was 84. Outpatient workload totaled 314,962 visits.

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 fraud and integrity awareness training 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Physician C&P.
- QM.
- RME.
- Suicide Prevention Safety Plans.

The review covered medical center operations for FY 2009 and FY 2010 through February 11, 2010, 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 medical center (*Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri,* Report No. 07-02836-66, February 4, 2008). The medical center

had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 254 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. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association, and Joint Commission (JC) standards.

We conducted onsite inspections of the hemodialysis unit; the locked MH unit; the emergency department; outpatient clinic areas; and inpatient medical, surgical, intensive care, and CLC units. The medical center maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. Medical center managers conducted quarterly MH EOC assessments for the locked MH unit and were pursuing corrective actions. However, we identified the following conditions that needed improvement.

Hemodialysis Unit. We reviewed 12 months of culture reports (water and dialysate[1]) and found that staff inconsistently performed and documented biological testing and the required follow-up action. The Association for the Advancement of Medical Instrumentation requires monthly biological testing of water and dialysate and documentation of the action taken when results are out of range. In

[1] Liquid used to clean waste by pulling toxins from the blood during dialysis.

addition, medical center staff inconsistently collected performance improvement data for the prevention of infections on the unit. The JC requires infection control surveillance activities and analysis of data.

Respirator Fit Testing. We found that 14 (70 percent) of 20 selected staff identified as at risk of exposure to a harmful atmosphere, such as tuberculosis, had not received the annual respirator fit testing, training, and medical evaluation required by local policy and OSHA.

MH Environmental Hazard Training. We found that 4 (25 percent) of 16 selected staff had not completed the required annual MH environmental hazard training. Employees assigned to locked MH units and MSIT members are required to undergo annual training for the identification of environmental hazards that pose a risk to suicidal patients.[2]

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires staff to conduct hemodialysis unit biological testing, document the action taken when test results are out of range, and collect and analyze performance improvement data for the prevention of infections on the hemodialysis unit.

The VISN and Medical Center Directors concurred with the findings and recommendation. The hemodialysis contract provider will submit hemodialysis unit biological testing data and any required action plans, and the testing data and action plans will be routed to the Clinical Executive Board. The requirement to provide monthly culture and endotoxin results is now included in the Statement of Work for contract negotiation. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that staff identified as at risk of exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center recently

[2] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

completed a risk assessment that established a priority system for annual respirator fit testing, training, and medical evaluation. Fit testing for all identified employees will be completed by June 30, 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that all locked MH unit staff and MSIT members receive environmental hazard training.

The VISN and Medical Center Directors concurred with the finding and recommendation. A medical center policy outlining the requirements for this training will be written and implemented by June 30, 2010. Quarterly reports to monitor compliance will be routed through the EOC Committee. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the medical center had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining a safe environment. The medical center's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD, the hemodialysis unit, the OR, the endoscopy clinic, and the cystoscopy clinic. During our inspection, we observed a quick reference chart displayed in areas where staff process endoscopes. The chart grouped, by color and number, the scopes that were processed using the same SOPs. The chart also included the names of staff who were competent in cleaning endoscopes.

We determined that the medical center had established appropriate guidelines and monitored compliance. However, we identified the following areas that needed improvement.

Flash Sterilization. We reviewed 12 months of OR flash sterilization log documentation and found that flash sterilization was used in non-emergent situations. VA requires full sterilization procedures to be used for all

surgical instruments.[3] Flash sterilization (a shorter sterilization process) is to be used during a surgical procedure only in case of emergency, such as a dropped sterilized instrument.

SOPs. The most recent hemodialysis machine manufacturer's instructions were not maintained within close proximity to the hemodialysis unit, in accordance with VHA policy.[4]

PPE. Staff in the SPD decontamination area did not wear gloves at all times. VA requires staff to wear PPE at all times while in the decontamination area.[5] PPE required in this area includes gown, gloves, shoe covers, and face mask.

Competencies and Training. We found that two of four SPD staff competency and training records did not have documentation of required annual competency. In addition, 5 (50 percent) of 10 OR staff had not completed the required annual flash sterilization training and competency. VHA requires that all employees involved in the use and reprocessing of RME have documented training on the setup, use, reprocessing, and maintenance of specific RME for initial and annual competency validation.[6]

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that OR staff utilize flash sterilization only in cases of emergency and develop an ongoing monitoring process for flash sterilization.

The VISN and Medical Center Directors concurred with the findings and recommendation. The SPD Chief and the OR nurse manager will review the flash sterilization log daily. All instances of flash sterilization will be evaluated to determine appropriateness of use. A root cause analysis team has been chartered to review the flash sterilization process and to develop an ongoing process for monitoring. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[3] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[4] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[5] VA Handbook 7176.
[6] VHA Directive 2009-004.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that staff have manufacturers' instructions within close proximity for all RME, wear all required PPE while in RME decontamination areas, complete annual training for all pieces of RME, and have documentation of RME training and competencies.

The VISN and Medical Center Directors concurred with the findings and recommendation. Manufacturers' instructions have been placed in close proximity to all RME. All SPD staff competencies have been completed, and all OR staff have completed annual competencies for flash sterilization. PPE requirements have been clarified. The SPD Chief and OR nurse manager will monitor to ensure ongoing compliance. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center senior management team and QM personnel. We evaluated plans, policies, and other relevant QM documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. We evaluated 12 QM activities and determined that the medical center complied with VHA standards in 11 areas. We identified one area that needed improvement.

UM. VHA requires the Chief of Staff to appoint a designated and trained physician advisor.[7] Prior to February 2010, the UM physician advisor had not completed VHA required training in the use of standardized criteria.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the designated UM physician advisor completes and documents UM training prior to assuming the role.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Acting Chief of Staff

[7] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

completed the UM physician advisor training in February 2010. The corrective action is acceptable, and we consider this recommendation closed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for CLC residents and outpatients.

We randomly selected 10 CLC patients' medical records and found that staff had appropriately documented influenza vaccination information. However, we identified the following area that needed improvement.

Management of Erythropoiesis-Stimulating Agents. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12g/dL. Clinicians documented an action to address the hemoglobin level in 5 (50 percent) of the 10 cases. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, erythropoiesis-stimulating agents[8] should be used to maintain hemoglobin levels between 10 and 12g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently implement and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

The VISN and Medical Center Directors concurred with the finding and recommendation. A VISN 15 pharmacist clinic manages erythropoietin and other hematologic stimulating agents. Pharmacists will identify all veterans with active prescriptions for these medications and will verify that proper lab testing and dose adjustments are made. All patients receiving erythropoietin and other hematologic stimulating agents are enrolled in the erythropoietin clinic to assure correct management. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and

[8] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 18 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments usually occurred within the timeframes specified. We also found evidence that QM staff monitored and evaluated patient transfers. However, we identified the following area that needed improvement.

Inter-Facility Transfers. We reviewed transfer documentation for 10 patients transferred from the medical center's inpatient units and emergency department to other facilities. We found that none of the 10 patient records had all required documentation. Examples of missing documentation included advanced directive status and informed consent for transfer. VHA policy requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation.[9]

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete inter-facility transfer documentation in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center's electronic template had no field to document advanced directive status. The local template now includes this field. Instructional flyers have been posted, and education has been provided. Performance improvement staff will monitor documentation requirements for all patient transfers and will report monthly to Clinical Executive Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[9] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Review Activities Without Recommendations

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[10] We also reviewed meeting minutes that included discussions relevant to the review.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation (OPPE) had been developed and were in the final approval process. Although the physician profiles reviewed did not include all the current OPPE required data for the 2-year period prior to reprivileging, a newly developed template with objective criteria met requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and available performance data prior to recommending initial or renewal of requested privileges. Because a comprehensive process was in place to monitor performance, and data collection had been initiated, we made no recommendations.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[11]

A previous OIG review of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety

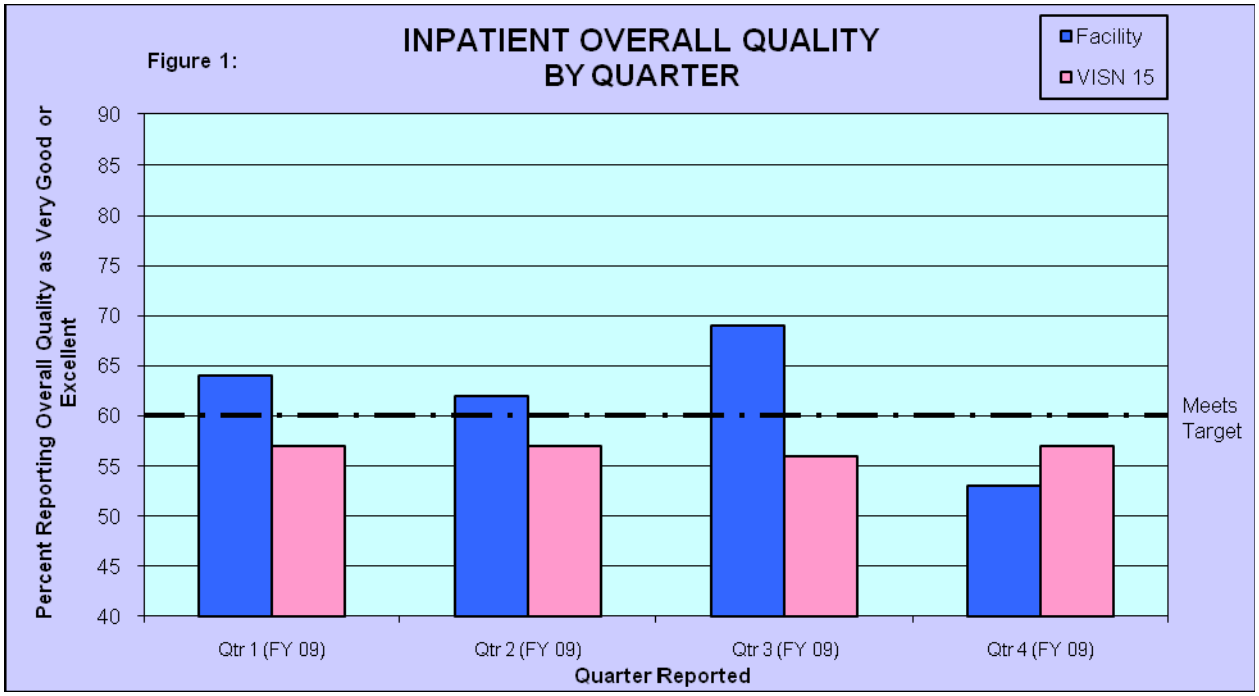
[10] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[11] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

plan development.[12] The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations.

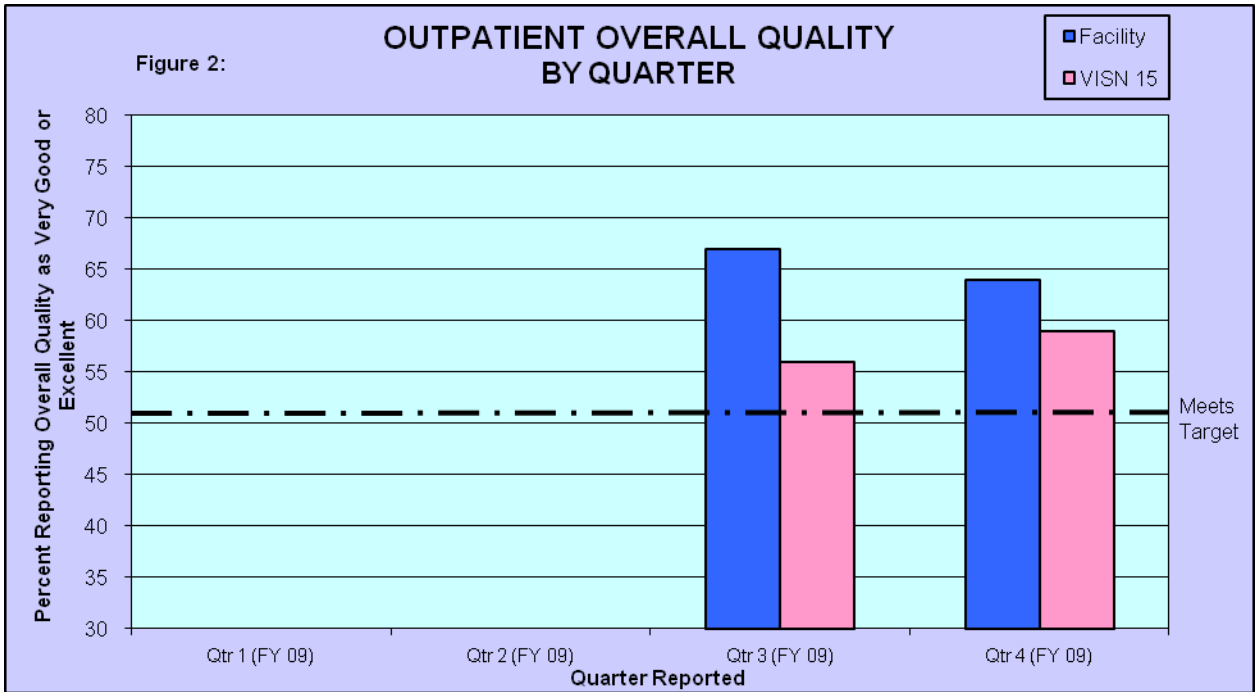
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the medical center's and VISN's overall inpatient satisfaction scores for FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[13] The target scores are noted on the graphs.

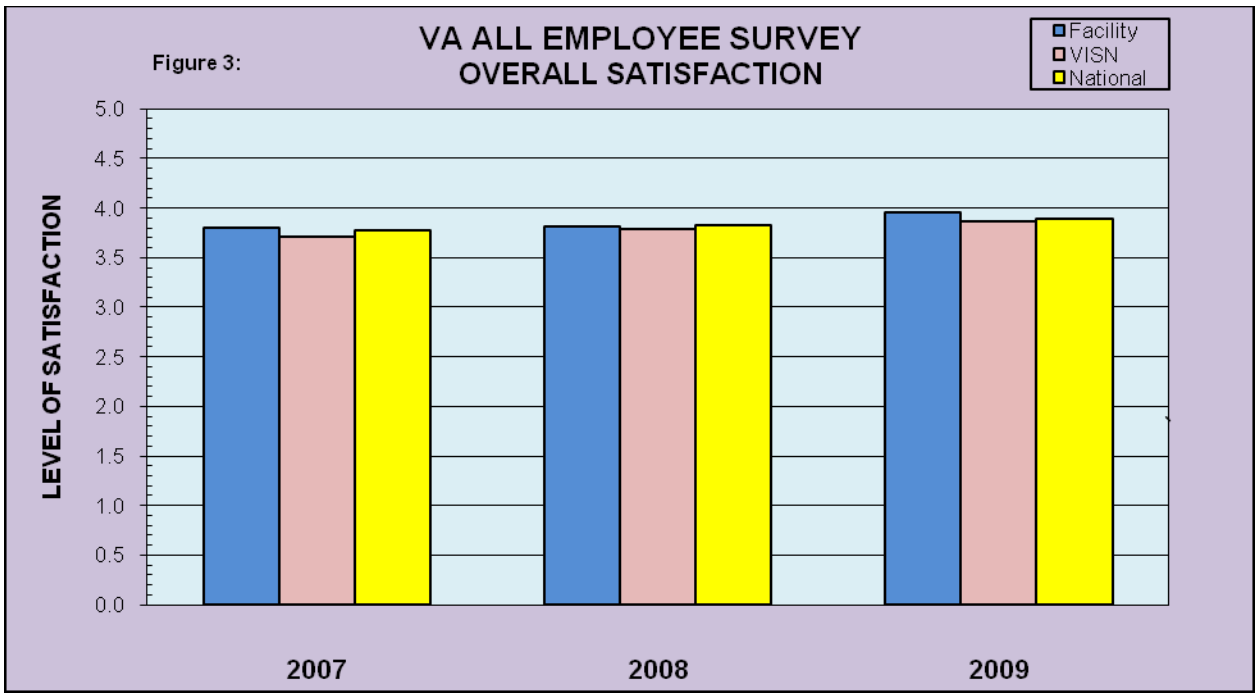


[12] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

[13] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 3 below shows the medical center's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 24, 2010

From: Director, VA Heartland Network (10N15)

Subject: **Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri**

To: Director Kansas City Healthcare Inspections Division (54KC)

Director, Management Review Service (10B5)

1. Attached please find Harry S. Truman Memorial VA's response to the draft report of the Combined Assessment Program Review.

2. I have reviewed the comments provided by the Medical Center Director and concur with the responses and proposed action plans to the recommendations outlined in the report.

JAMES R. FLOYD, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 23, 2010

From: Director, Harry S. Truman Memorial Veterans' Hospital (589A4/00)

Subject: **Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri**

To: Director, VA Heartland Network (10N15)

1. This is to acknowledge receipt and thorough review of the findings and recommendations of the Office of Inspector General Combined Assessment Program review conducted February 8-12, 2010. Columbia VA Medical Center concurs with the findings and recommendations and appreciates the opportunity to review the draft report. Corrective action plans have been developed or implemented for all recommendations.

2. Our appreciation is extended to the entire OIG CAP Team. Every member of the team was consultative and professional and provided excellent feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality care we provide for our veterans.

Sallie Houser-Hanfelder, FACHE

SALLIE HOUSER-HANFELDER, FACHE

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 the VISN Director ensure that the Medical Center Director requires staff to conduct hemodialysis unit biological testing, document the action taken when test results are out of range, and collect and analyze performance improvement data for the prevention of infections on the hemodialysis unit.

Concur Target date: Completed

The VA Medical Center Columbia, Missouri, agrees to require staff to conduct hemodialysis unit biological testing, document action(s) taken when test results are out of range, and to collect and analyze performance improvement data for the prevention of infections on the hemodialysis unit. Reporting processes exist for out of range endotoxin testing; however, documentation of the process could not be located. Effective immediately, the hemodialysis contract provider will submit hemodialysis unit biological testing data and required out of range action plans to the Contracting Officer Technical Representative. Hemodialysis unit biological testing data and action plans will route through the Infection Control Committee to the Clinical Executive Board. The requirement to provide monthly culture and endotoxin results according to AAMI and CDC guidelines is included in the Statement of Work for contract negotiation.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that staff identified as at risk of exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation.

Concur Target date: June 30, 2010

The VA Medical Center Columbia, Missouri, agrees that staff identified as at risk of exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation. Processes exist for conducting required respirator fit testing, training and medical evaluations. The recent completion of a risk assessment, based on the risk of exposure to airborne transmissible disease, including H1N1, established a priority system for annual respirator fit testing, training, and medical evaluation. Fit testing based on this priority system for all identified employees will be completed by June 30, 2010. New employees determined to be at risk will have fit

testing completed during New Employee Orientation. Quarterly reports to monitor compliance that staff identified as at risk of exposure to a harmful atmosphere receive annual respirator fit testing, training, and medical evaluation will route through the Environment of Care Committee.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all locked MH unit staff and MSIT members receive environmental hazard training.

Concur Target date: June 30, 2010

The VA Medical Center Columbia, Missouri, agrees that all locked MH unit staff and MSIT members receive environmental hazard training. Processes exist that require all staff who worked on the locked MH unit and MSIT members to complete the environmental hazard training annually. A Medical Center policy will be written and implemented outlining the requirements for this training by June 30, 2010. Quarterly reports to monitor compliance will route through the Environment of Care Committee.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that OR staff utilize flash sterilization only in cases of emergency and develop an ongoing monitoring process for flash sterilization.

Concur Target date: April 17, 2010

The VA Medical Center Columbia, Missouri, agrees that OR staff utilizes flash sterilization only in cases of emergency and develop an ongoing monitoring process for flash sterilization. Processes exist for the monitoring of flash sterilization and reporting through the Infection Control Committee. The SPD Chief and the OR Nurse manager will review the flash sterilization log daily to assure detailed and complete documentation of use. All instances of flash sterilization will be evaluated to determine appropriateness of use. A Root Cause Analysis team has been chartered to review the flash sterilization process and make recommendations to ensure compliance with policy and develop an ongoing process for monitoring. The report is due April 17, 2010.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that staff have manufacturers' instructions within close proximity for all RME, wear all required PPE while in RME decontamination areas, complete annual training for all pieces of RME, and have documentation of RME training and competencies.

Concur Target date: Completed

The VA Medical Center Columbia, Missouri, agrees that staff have manufacturers' instructions within close proximity for all RME, wear all required PPE while in RME decontamination areas, complete annual training for all pieces of RME, and document RME training and competencies. Manufacturer instructions have been placed within close proximity of RME. PPE requirements regarding the transfer of items from decontamination to sterilization have been clarified. Staff is required to apply new gloves immediately prior to passing an item through the window to sterilization. SPD lead and supervisory staff is responsible to ensure staff wears correct PPE. The VA Medical Center Columbia, Missouri has processes in place for SPD staff competencies and proper PPE. All SPD staff competencies were complete as of 3/10/10. All OR staff have completed annual competencies for flash sterilization. Proper PPE use has been incorporated as part of orientation to ensure new staff receive the appropriate training/competency checks. The Chief SPD and OR Nurse Manager will monitor to ensure ongoing compliance.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the designated UM physician advisor completes and documents UM training prior to assuming the role.

Concur Target date: Completed

The VA Medical Center Columbia, Missouri, agrees that the designated UM physician advisor completes and documents UM training prior to assuming the role. The Acting Chief of Staff completed the Utilization Management Physician Advisor training in February 2010.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians consistently implement and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Concur Target date: Completed

The VA Medical Center Columbia, Missouri, agrees that clinicians consistently implement and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL. A VISN 15 pharmacist clinic provides the management of erythropoietin and other hematologic stimulating agents. Pharmacists with an approved scope of practice use the computerized data system to identify all veterans with active prescriptions for these medications and to verify that proper lab testing and dose adjustments are made. All patients receiving erythropoietin and other hematologic stimulating agents are enrolled in the Erythropoietin clinic to assure correct management and documentation.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete inter-facility transfer documentation in accordance with VHA policy.

Concur Target date: Completed

The VA Medical Center Columbia, Missouri, agrees that staff complete inter-facility transfer documentation in accordance with VHA policy. The VA Medical Center Columbia, Missouri had a process in place for monitoring compliance with completion of the inter-facility transfer documents at the time of the OIG CAP review. The national template from the HIMS Web site for inter-facility transfers was being utilized by the Medical Center. A subsequent review of the Medical Center CPRS template revealed no field for documenting advance directive status. The local template now includes this field. Flyers with instructions have been posted and education provided. The requirement to complete the template note and consent form will continue to be an area of emphasis. Performance Improvement staff will monitor documentation requirements for all patient transfers and will report monthly to Clinical Executive Board.

OIG Contact and Staff Acknowledgments

Contact	Dorothy Duncan, Associate Director Kansas City Office of Healthcare Inspections (816) 997-6966
Contributors	Reba B. Ransom, Team Leader Stephanie Hensel James Seitz James Werner, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network (10N15)
Director, Harry S. Truman Memorial Veterans' Hospital (589A4/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Christopher S. Bond, Claire McCaskill
U.S. House of Representatives: Roy Blunt, Jo Ann Emerson, Sam Graves, Blaine Luetkemeyer, Ike Skelton

This report is available at http://www.va.gov/oigpublications/reports-list.asp.