Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03074-221

Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota

August 12, 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 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.

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
EOC	environment of care
facility	St. Cloud VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RME	reusable medical equipment
SOARS	System-Wide Ongoing Assessment and Review Strategy
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota

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 7, 2010.

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

- Coordination of Care
- Medication Management
- Physician Credentialing and Privileging
- Quality Management
- Suicide Prevention Safety Plans

The facility's reported accomplishments were opening a new community based outpatient clinic, establishing a nationally recognized method for Fentanyl patch destruction, and receiving a national award for canteen staff friendliness and courtesy.

Recommendations: We made recommendations in the following two activities:

Reusable Medical Equipment: Supply, Processing, and Distribution staff need to clean reusable medical equipment according to the manufacturers' instructions. Information pertaining to staff competencies and standard operating procedure compliance must be reported to the Executive Committee.

Environment of Care: Staff must routinely inspect and remove from service patient wheelchairs with damage to padded surfaces.

Comments

The Acting 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.

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

Objectives and Scope

Objectives

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

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 seven activities:

- COC
- EOC
- Medication Management
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through June 9, 2010, and was done in accordance with OIG SOPs 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. Cloud VA Medical Center, St. Cloud, Minnesota, Report No. 07-00708-170, July 18, 2007). The facility had corrected all findings from our prior CAP review.

During this review, we also presented crime awareness briefings for 227 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.

Reported Accomplishments

Alexandria CBOC

The Alexandria CBOC opened for business on September 21, 2009. It is located in west central Minnesota and serves veterans in Douglas, Grant, Pope, Stevens, Todd, and Wadena counties. CBOC enrollment is estimated at 3,500 veterans. Services offered include primary care, chronic disease management, preventative health care, MH care, home care services, and specialty care referrals to the VA medical centers in St. Cloud and Minneapolis. This is the facility's third CBOC.

Best Practice Recognition: Fentanyl Patch Destruction

A new process for Fentanyl patch destruction was recognized during the FY 2010 SOARS site visit. This process was later recognized by The JC and was a feature article in the newsletter publication *Inside the Joint Commission.* An interdisciplinary team was formed to modify the destruction process for Fentanyl patches due to restrictions from the local water treatment facility. Modifications included placing secured destruction bins on each ward; requiring nurse documentation of Fentanyl patch placement in the bin; arranging for secure, central collection of all the bins; and requiring documented confirmation by the hazardous waste disposal company of the destruction of the Fentanyl patches.

National Customer Service Award

In FY 2009, the facility's canteen staff received a national award for highest overall score for customer friendliness and courtesy. The canteen was ranked the best among more than 170 VA medical center canteens in the nation.

Results

Review Activities With Recommendations

RME

The purpose of this review was to evaluate whether the facility 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 an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD and gastrointestinal endoscopy reprocessing areas. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines.

We reviewed the reprocessing SOPs for six pieces of RME and found that they were current and consistent with the manufacturers' instructions. We also reviewed the competency folders and training records of employees who demonstrated cleaning procedures for six selected pieces of RME. We found that annual competencies and training were current and consistently documented. However, we identified the following areas that needed improvement.

Cleaning. VHA requires[1] that staff clean RME according to the manufacturers' instructions. The staff we observed cleaning two pieces of RME that required certain steps in the cleaning process to be timed did not properly time all the steps as required by the SOPs.

Executive Committee Reporting. VHA requires[2] that validation of initial and ongoing competency of staff, results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management related activities are reported to the Executive Committee. Validation of initial and ongoing competency of staff and results of compliance with established SOPs were not reported to the Executive Committee.

[1] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[2] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

Recommendations

1. We recommended that SPD staff clean RME according to the manufacturers' instructions.

2. We recommended that required information pertaining to staff competencies and SOP compliance is reported to the Executive Committee.

EOC

The purpose of this review was to determine whether the facility complied with selected infection control standards and maintained a clean and safe health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, and JC standards.

We conducted onsite inspections of the locked inpatient MH unit, the CLC units, the ventilator unit, the dementia unit, the rehabilitation unit, the urgent care clinic, the audiology and optometry clinics, the primary care clinics, the women's health clinic, the physical therapy clinic, and the MH outpatient clinics. The facility maintained a generally clean and safe environment. Staff and nurse managers expressed satisfaction with the responsiveness of the housekeeping staff on their units. Facility managers conducted quarterly MH EOC assessments for the locked inpatient MH unit and were pursuing corrective actions. However, we identified the following area that needed improvement.

Wheelchairs. To prevent the spread of infection, The JC requires that padded patient equipment remain intact. We found that the arm rests of four wheelchairs on the CLC units were cracked and in need of repair. Cracked surfaces cannot be adequately cleaned between patient use, and sharp edges may cause skin irritation and breakdown.

Recommendation

3. We recommended that staff routinely inspect patient wheelchairs and remove from service wheelchairs with damage to padded surfaces.

Review Activities Without Recommendations

COC

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

VHA requires[3] that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's acute inpatient unit, emergency department, or urgent care clinic to another facility. We determined that clinicians consistently documented the required information for the patient transfers reviewed.

VHA policy[4] 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 10 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. For CLC residents, we reviewed the process for and administration of influenza vaccinations.

The facility had appropriate policies for the administration of influenza vaccinations. Influenza vaccinations were documented for CLC residents, and clinical staff followed the established protocol for a delay in receipt of vaccines. Also, although the pharmacy is closed at night and in the evening, we found that the facility had a qualified pharmacist to answer questions and had an adequate retrospective review process. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[5] We also

[3] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[4] VHA Handbook 1907.01, *Health Information Management and Heath Records,* August 25, 2006.
[5] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. FPPE was appropriately implemented for newly hired physicians. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

QM

The purposes of this review were to evaluate (a) whether the system had a comprehensive QM program designed to monitor patient care activities and coordinate improvement efforts and (b) whether senior managers actively supported the program's activities and appropriately responded to QM results. We reviewed 12 QM and safety processes, and we evaluated policies, PI data, and other relevant documents. We interviewed appropriate senior managers, patient safety employees, and the QM Coordinator.

The QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and used to improve patient care and patient safety. Appropriate review structures were in place for all 12 program activities reviewed. 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.[6]

A previous OIG review of suicide prevention programs in VHA facilities[7] found a 74 percent compliance rate with safety plan development. 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.

Comments

The Acting VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 10–13, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

[6] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[7] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Facility Profile[8]		
Type of Organization	Non-tertiary	
Complexity Level	3	
VISN	23	
CBOCs	Alexandria, MN Brainerd, MN Montevideo, MN	
Veteran Population in Catchment Area	82,500	
Type and Number of Operating Beds: • **Acute MH**	15	
• **CLC (nursing home)**	225	
• **Residential Rehabilitation**	148	
Medical School Affiliation(s)	None	
• **Number of Residents**	0	
	Current FY (through March 2010)	**Prior FY**
Resources (in millions):		
• **Budget**	$188.9	$180.3
• **Medical Care Expenditures**	$ 88.4	$180.0
FTE	1,258.8 (actual)	1,229.4 (cum)
Workload:		
• **Number of Unique Patients**	28,443	33,958
• **Inpatient Days of Care:**		
o **Acute Care**	1,171	3,353
o **CLC**	35,818	68,517
Hospital Discharges	1,125	2,331
Cumulative Average Daily Census (including CLC patients)	316	309
Cumulative Occupancy Rate	86.4%	82.1%
Outpatient Visits	153,665	281,376

[8] All data provided by facility management.

VHA Satisfaction Surveys

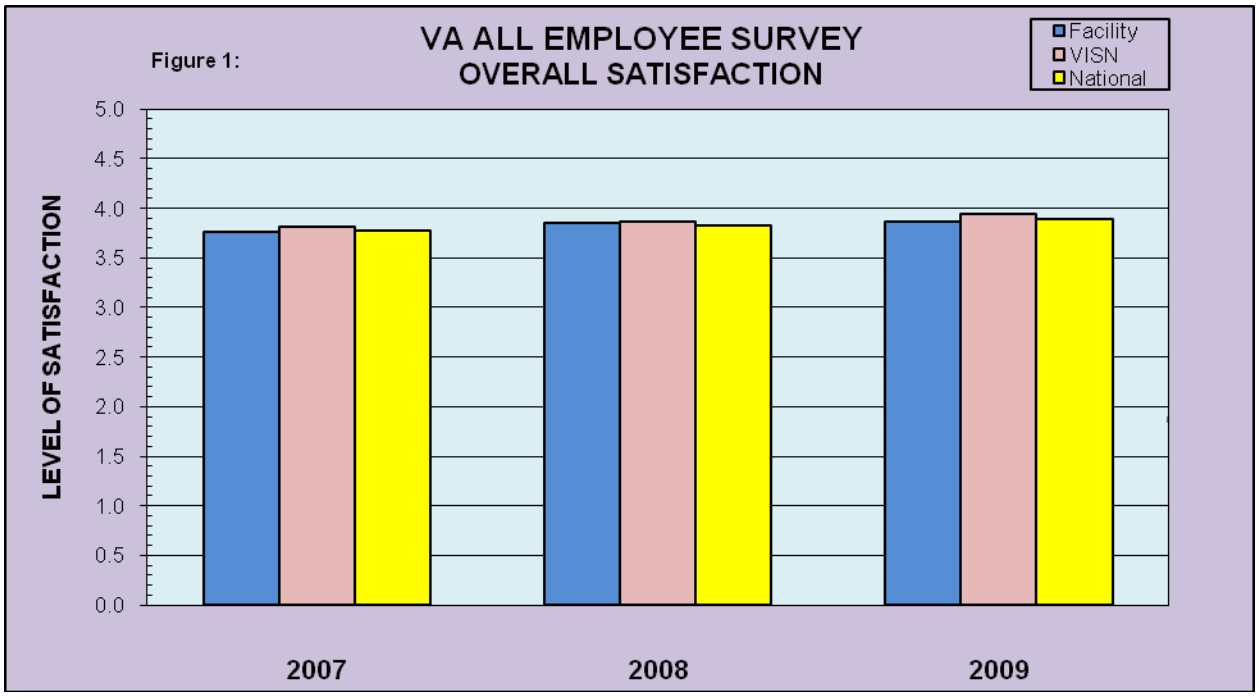
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows the facility's and VISN's calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall outpatient satisfaction score and target for the 1st quarter of FY 2010.

Table 1

	FY 2009		FY 2010
	Inpatient Score	Outpatient Score	Outpatient Score 1st Quarter
Facility	NA[9]	54.81	57.3 (target 56)
VISN	67.54	54.33	56.5 (target 56)

Employees are surveyed annually. Figure 1 below shows the facility'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.

Figure 1:



[9] Facility inpatient overall quality is not included because this facility does not provide inpatient services.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 19, 2010

From: Acting Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the St. Cloud VA Medical Center, St. Cloud, MN**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (VHA CO 10B5 Staff)

I concur with the recommendations and approve of the action plans as outlined by St. Cloud VA Medical Center.

Barry D. Sharp

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 14, 2010

From: Director, St. Cloud VA Medical Center (656/00)

Subject: **CAP Review of the St. Cloud VA Medical Center, St. Cloud, MN**

To: Acting Director, VA Midwest Health Care Network (10N23)

1. I concur with the recommendations presented in this Combined Assessment Program Review of the St. Cloud VA Medical Center.

2. Attached are the facility actions taken as a result of these findings.

3. Thank you for these opportunities for improvement. The IG Team conducted the audit in a very professional, helpful manner which made the site visit productive and educational for our staff.

4. If you have additional questions or need further information, please contact me at (320) 255-6480, ext. 6315.

Barry I Bahl
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 SPD staff clean RME according to the manufacturers' instructions.

Concur

Target date for completion: August 31, 2010

Timers are in place in the reprocessing rooms. The Chief of SPD has reinstructed staff to follow manufacturers' instructions. An unannounced site visit for scope cleaning/RME by VISN 23 leaders occurred on July 12, 2010 resulting in substantial compliance. Locally, the scope cleaning process will be randomly monitored on a monthly basis by appropriate staff to ensure SOPs are being followed.

Recommendation 2. We recommended that required information pertaining to staff competencies and SOP compliance is reported to the Executive Committee.

Concur

Target date for completion: September 30, 2010

Staff competencies and SOP compliance have initially been reported to the Medical Center Infection Prevention Committee, which will then be reported on to the Medical Executive Board.

Recommendation 3. We recommended that staff routinely inspect patient wheelchairs and remove from service wheelchairs with damage to padded surfaces.

Concur

Target date for completion: September 30, 2010

The Extended Care and Rehabilitation Safety Policy, Attachment L, has been amended to include the following: wheelchairs and gerichairs in CLC units will be cleaned and inspected in the wheelchair clinic on a scheduled monthly basis. An inventory of all wheelchairs will be kept on the wards and the ward clerks will post cleaning schedules on the appointment sheets. Incentive therapy workers transport the wheelchairs back/forth from the wheelchair clinic. After each chair is cleaned, it is inspected for needed repairs before returning back to circulation. Staff will also be trained to remove chairs/equipment that are grossly soiled or in disrepair and returned to the wheelchair clinic on an as needed basis. For stock wheelchairs used throughout the medical

center, the chairs are collected for regular cleaning and repair by incentive therapy workers. A statement outlining this process will be entered into the FM-01 Safety, Occupational Health, and Fire Protection Manual.

OIG Contact and Staff Acknowledgments

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