Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03747-15

Combined Assessment Program Review of the Sioux Falls VA Medical Center Sioux Falls, South Dakota

October 28, 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.

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
CRD	chronic renal disease
EMR	electronic medical record
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	Sioux Falls VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
IV	intravenous
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
MSIT	Multidisciplinary Safety Inspection Team
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RME	reusable medical equipment
RSC	Radiation Safety Committee
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Sioux Falls VA Medical Center, Sioux Falls, SD

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 August 9, 2010.

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

- Physician Credentialing and Privileging
- Suicide Prevention Safety Plans

Recommendations: We made recommendations in the following six activities:

Reusable Medical Equipment: Managers need to evaluate and document competencies and provide and document annual training for all pieces of reusable medical equipment. All standard operating procedures available to staff need to reflect current operating procedures.

Coordination of Care: Providers need to complete all required inter-facility transfer documentation and comply with all discharge documentation requirements. Patients or caregivers need to receive written discharge instructions.

Environment of Care: The mental health Multidisciplinary Safety Inspection Team needs to include all designated disciplines. Staff who work on the locked inpatient mental health unit must receive initial training on the identification of environmental hazards that pose a risk to suicidal patients. Nursing staff need to receive training on required glucometer cleaning.

Medication Management: Clinicians need to document all required influenza vaccine elements and consistently take and document actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter. The pharmacy needs to implement a process to document reviews of all medication orders placed during the time the pharmacy is not open.

Quality Management: The medical record review process needs to include monitoring the use of the "copy and paste" functions in the electronic medical record.

Magnetic Resonance Imaging Safety: Managers need to ensure that staff receive appropriate safety training prior to working in the magnetic resonance imaging area.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director 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 eight activities:

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

The review covered facility operations for FY 2009 and FY 2010 through August 13, 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 Sioux Falls VA Medical Center, Sioux Falls, South Dakota,* Report No. 07-02705-49, January 2, 2008). The facility had corrected all findings from our previous CAP review.

During this review, we also presented crime awareness briefings for 287 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

Results

Review Activities With Recommendations

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 SPD and the OR satellite reprocessing area. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines.

VHA requires[1] device-specific SOPs for RME to be established in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for three pieces of RME in the OR. Managers were initially unable to provide us with an SOP for the orthopedic instruments. Because the SOP was located while we were onsite, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

[1] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

Competencies and Training. VHA requires[2] competencies to be evaluated and training to be provided annually on the set-up, use, reprocessing, and maintenance of specific RME. We reviewed the competency folders and training records of two SPD employees and three employees in the satellite areas who correctly demonstrated the cleaning and reprocessing of nine pieces of RME. We found that annual competencies for the dental instruments and the orthopedic instruments had not been completed. In addition, documentation of annual training had not been completed for the bronchoscope, the colonoscope, the cystoscope, the transesophageal echocardiogram probe, the dental instruments, the orthopedic instruments, and the internal pathways of a hemodialysis machine.

We also reviewed the competency folders of nine OR employees who operate the flash sterilizer and found that all nine lacked documentation of an annual competency.

SOPs. VHA requires[3] device-specific SOPs for RME to be established in accordance with the manufacturers' instructions. We requested the SOPs and manufacturers' instructions for six pieces of RME in SPD. The SOPs were maintained in three locations in SPD. Although managers were able to provide a current SOP for each piece of RME, each location had different sets of SOPs. Some sets had older SOP versions that had not been updated, and other sets were missing SOPs.

Recommendations

1. We recommended that competencies be evaluated and training be provided annually for all pieces of RME and that competencies and training be documented.

2. We recommended that all SOPs available to staff reflect current operating procedures.

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.

[2] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.
[3] VHA Directive 2009-004.

VHA requires[4] that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers be 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. However, we identified the following areas that needed improvement.

Inter-Facility Transfers. VHA policy requires[5] specific information (such as the level of services required, medical and/or behavioral stability, and presence of advance directives) to be recorded in the transfer documentation. We reviewed transfer documentation for 10 patients transferred from the facility's acute inpatient unit, emergency department, or urgent care clinic to another facility. We found that providers did not document all required information for any of the 10 patients. Missing information included documentation of advance directives, the mode of transportation, and requirements during transport.

Discharges. VHA policy requires[6] that providers include information regarding medications, diet, activity level, and follow-up appointments in patient discharge instructions. In addition, The JC requires that clinicians provide patients with written discharge instructions.

We reviewed the medical records of 12 discharged patients and found deficiencies in 6 (50 percent) of the records. Three of the six records with deficiencies lacked documentation regarding discharge activity levels, special dietary instructions, and follow-up appointments. The remaining three records had no documentation that the patients received written discharge instructions.

Recommendations

3. We recommended that providers complete all required inter-facility transfer documentation.

4. We recommended that discharge documentation include all required elements and that patients or caregivers receive written discharge instructions.

EOC

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

[4] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[5] VHA Directive 2007-015.
[6] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, NFPA, and JC standards.

We inspected the emergency department, the outpatient clinic areas, the hemodialysis unit, all inpatient (locked MH, medical/surgical, and intensive care) units, and the CLC. 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. However, we identified the following conditions that needed improvement.

MSIT Membership and MH Environmental Hazards Training. VHA policy requires[7] that facilities have an MSIT with designated disciplines to assess EOC vulnerabilities on the locked inpatient MH unit. While the facility had implemented an MSIT, it did not include five of the nine designated disciplines.

In addition, employees assigned to locked inpatient MH units are required to undergo initial and annual training on the identification of environmental hazards that pose a risk to suicidal patients. Six (40 percent) of 15 selected staff had not completed the required initial MH environmental hazards training.

Infection Control. Local policy requires staff to clean and disinfect glucometers (blood sugar monitors) after each patient use. Nursing staff we interviewed were not aware of this requirement.

Recommendations

5. We recommended that MSIT membership include all designated disciplines and that all employees who work on the locked inpatient MH unit receive the required initial training on the identification of environmental hazards that pose a risk to suicidal patients.

6. We recommended that nursing staff receive training on the required cleaning of glucometers.

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 outpatients and CLC residents

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

and identified the following three areas that needed improvement.

CLC Influenza Vaccinations. VHA requires[8] several items to be documented for each influenza vaccine given, including the lot number, manufacturer, and the date and edition of the Vaccine Information Statement. We reviewed the medical records of 10 CLC residents and found that three (30 percent) records did not contain documentation of all the required elements.

Management of ESAs. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, ESAs[9] should be used to maintain hemoglobin levels between 10 and 12 g/dL. Hemoglobin levels greater than 12 g/dL increase the risk of serious conditions and death. We reviewed the medical records of 10 CRD outpatients with hemoglobin levels greater than 12 g/dL and found that none of the records contained documentation of an action to address the hemoglobin levels.

Pharmacy Processes. JC standards require several processes to be in place at health care facilities where the onsite pharmacy is not open 24 hours per day, 7 days per week. These processes include review by a qualified health professional in the absence of a pharmacist and retrospective review of all medication orders during this period by a pharmacist for allergies, appropriateness, and interactions. The pharmacy at the facility operates from 7:30 a.m. to 8:30 p.m. Monday through Friday and from 7:30 a.m. to 6:00 p.m. Saturday and Sunday. A pharmacist was available at another location to review new orders, but documentation of the retrospective review process was not consistent and did not include all required elements.

Recommendations

7. We recommended that clinicians consistently document all required influenza vaccine elements.

8. We recommended that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12 g/dL.

9. We recommended that the pharmacy implement a consistent process for documenting retrospective review of

[8] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.
[9] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.

all medication orders placed during the time the onsite pharmacy is not open.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents. We also interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for most of the required QM activities. However, we identified the following area that needed improvement.

Medical Record Review. VHA requires[10] that each facility have rules guiding the use of the "copy and paste" functions in the EMR. Although the facility maintained a process to monitor open and closed medical records on an ongoing basis, this process did not include the monitoring of the "copy and paste" functions in the EMR.

Recommendation

10. We recommended that the facility's medical record review process include monitoring the use of the "copy and paste" functions in the EMR.

MRI Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment as required by The JC.

The facility opened an MRI suite in May 2010 and had appropriate barriers to prevent unauthorized or accidental access to the MRI areas. Patients in the magnet room were directly observed at all times. Two-way communication was

[10] VHA Handbook 1907.01.

available between the patient and the MRI technologist, and the patient had access to a push-button call system while in the scanner.

We reviewed the medical records of 10 patients who received an MRI prior to our visit and found that all records contained the MRI screening form. We identified the following area that needed improvement.

Training. VA guidelines require[11] that staff who have access to the MRI suite receive MRI safety education. We reviewed training records and found that two of six MRI personnel and five of six non-MRI personnel had not completed MRI safety training prior to the opening of the MRI suite in May 2010.

Recommendation

11. We recommended that managers ensure that staff receive appropriate safety training prior to working in the MRI area.

Review Activities Without 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[12] elements in C&P files and physician profiles. We also 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.

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

[11] VA Radiology, "Online Guide," <http.//vaww1.va.gov/Radiology/page.cfm?pg=167>, updated December 20, 2007, Secs. 4.1–4.3.
[12] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

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.[13]

A previous OIG review of suicide prevention programs in VHA facilities[14] 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 VISN Director and Acting Facility Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 14–20, for the full text of the Directors' comments.) We consider Recommendation 2 closed. We will follow up on the planned actions for the open recommendations until they are completed.

[13] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[14] *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[15]		
Type of Organization	VA medical center	
Complexity Level	2	
VISN	23	
CBOCs	Aberdeen, SD Sioux City, IA Spirit Lake, IA Wagner, SD Watertown, SD	
Veteran Population in Catchment Area	73,616	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	39	
• **CLC/Nursing Home Care Unit**	58	
• **Other**	6 mental health	
Medical School Affiliation(s)	The University of South Dakota's Sanford School of Medicine	
• **Number of Residents**	18	
	Current FY (through August 2010)	**Prior FY**
Resources (in millions):		
• **Total Medical Care Budget**	$155	$154
• **Medical Care Expenditures**	$155	$154
Total Medical Care FTE	829	817.3
Workload:		
• **Number of Station Level Unique Patients**	24,475	26,466
• **Inpatient Days of Care:**		
o **Acute Care**	6,657	7,495
o **CLC/Nursing Home Care Unit**	15,496	19,627
Hospital Discharges	1,528	1,839
Total Average Daily Census (including all bed types)	81.1	74.3
Cumulative Occupancy Rate	76%	69.2%
Outpatient Visits	190,540	244,268

[15] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation?**
EOC			
1. Lock IV carts when not in use.	IV medication carts corrective action plan remains in place; keyless entry self-locking carts are in place.	Y	N
2. Date multiple dose medication vials as specified by local policy.	Corrective actions remain in place with ongoing monitoring.	Y	N
3. Maintain an accurate inventory of radioactive materials.	An annual radioactive inventory letter is sent out to every facility department. This inventory explains regulations on possession and the process of obtaining radioactive sources within our facility. Each service chief or supervisor must inventory their departments by checking an appropriate box, signing the letter, and returning the letter to the Nuclear Medicine Department. The facility-wide inventory was discussed at the RSC meeting on March 11, 2008, and is discussed at the RSC meeting with the Chief of Staff, Radiation Safety Officer, Administrative Officer of Imaging Services, Lead Nuclear Medicine Technologist, Industrial Hygienist, Research delegate, Nursing delegate, and Medical Physicist on an annual basis. The inventory letters are kept in the Nuclear Medicine Department, which is mandated to conduct its own sealed source inventory every 6 months and record it into a database. A hard copy is printed for the Radiation Safety Officer to sign. The Nuclear Medicine sealed source inventory is also reported to the RSC.	Y	N

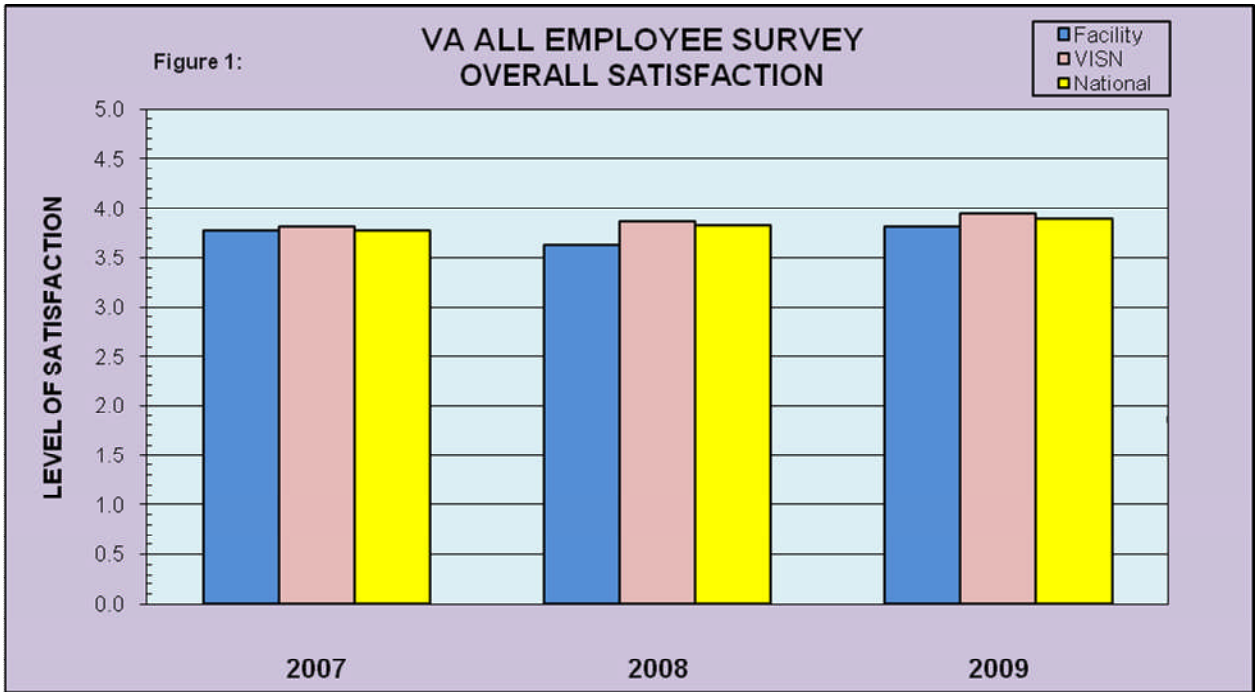
VHA Satisfaction Surveys

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 facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	63.78	60.06	56.7	60.5	61.3	57.2
VISN	67.54	54.33	64.5	63.6	56.5	56.9
VHA	65.01	52.87	63.3	63.9	54.7	55.2

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[16] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	14.06	9.58	17.04	19.85	21.50	14.21
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[16] CHF is a weakening of the heart's pumping power. With heart failure, your body doesn't get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 6, 2010

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

Subject: **CAP Review of the Sioux Falls VA Medical Center, Sioux Falls, SD**

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

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

I concur with the planned actions to be taken by Sioux Falls VAMC regarding the three identified recommendations. A date for completion is noted for each item.

JANET P. MURPHY, MBA
VISN 23 Network Director

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 5, 2010

From: Acting Director, Sioux Falls VA Medical Center (438/00)

Subject: **CAP Review of the Sioux Falls VA Medical Center, Sioux Falls, SD**

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

1. We appreciated the opportunity to review the draft Combined Assessment Program Review report for the survey conducted at the Sioux Falls VA Medical Center on the week of August 9, 2010.

2. Attached are comments regarding actions taken to complete the identified items and those that are currently in process to improve and resolve non-compliance in the areas cited.

3. We would like to extend our appreciation to the IG team members for their professionalism. Their collegial manner resulted in a productive and beneficial survey process for the medical center.

(original signed by:)
SARA ACKERT, MS

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 competencies be evaluated and training be provided annually for all pieces of RME and that competencies and training be documented.

Concur

Target date for completion: December 1, 2010

Annual competency and training for all pieces of RME: On August 9, 2010, the surgery nurse manager researched other facilities' competencies for flash sterilization. From the researched competencies, the nurse manager developed a competency for our facility on August 9, 2010. This competency outlines the conditions under which flash sterilization can be used, the procedure for flash sterilization, and the tests that need to be run on the sterilizer prior to use. Staff training and verification of competencies was completed and documented on August 9, 2010, and will be completed on an annual basis. Competencies and training will be completed and documented for all staff responsible for the cleaning of dental instruments, orthopedic instruments, bronchoscope, colonoscope, cystoscope, transesophageal echocardiogram probe and the internal pathways of the hemodialysis machine by November 30, 2010.

Recommendation 2. We recommended that all SOPs available to staff reflect current operating procedures.

Concur

Target date for completion: Completed August 11, 2010

Standard Operating Procedure (SOP) Maintenance Action Plan: On August 11, 2010, SOPs were updated to contain relevant information on currently used equipment. Current SOP locations were checked to determine which SOPs were missing from each location; copies were made of the SOPs and placed in each of the three areas. SOPs are maintained in three locations (computer files, flipping board, and SOP binder) to allow availability at their required access points within the decontamination area.

Recommendation 3. We recommended that providers complete all required inter-facility transfer documentation.

Concur

Target date for completion: October 13, 2010

Inter-Facility Transfer Action Plan: The Inter-facility transfer out form 10-2649A was revised on August 24, 2010, to include the requirement to send Advance Directive (if available) with all veterans who transfer out of facility. A memo was sent on September 30, 2010, to all registered nurses, ward clerks and Administrative Officers of the Day (AOD) defining each person's responsibility in the process of sending Advance Directives. Attachments to the Memo included: an updated Standard Operating Procedure for completing inter-facility transfer, and a screen shot of new 'Inter-facility Transfer out Form 10-2649A. Monitoring of inter-facility transfer process is done concurrently with 'real-time' feedback to staff participating in the inter-facility process. Monthly reports will be sent to Clinical Quality Council to ensure Executive Leadership over sight effective October 13, 2010.

Recommendation 4. We recommended that discharge documentation include all required elements and that patients or caregivers receive written discharge instructions.

Concur

Target date for completion: November 15, 2010

The 'Discharge Note Nursing' was revised on September 7, 2010, to include additional details regarding disposition/education provided at discharge. Also on September 7, 2010, an e-mail was sent to all acute care Nurse Managers to outline the changes. A discharge planning reference guide with a screen shot was distributed to staff. Verification of receipt of the discharge planning reference guide for all active staff members will be completed by November 15, 2010. Concurrent monitoring is being done for all discharges. Monitors will be reported monthly to Clinical Quality Council starting October 13, 2010. The template revision was fully implemented on September 7, 2010.

Recommendation 5. We recommended that MSIT membership include all designated disciplines and that all employees who work on the locked inpatient MH unit receive the required initial training on the identification of environmental hazards that pose a risk to suicidal patients.

Concur

Target date for completion: November 15, 2010

Multidisciplinary Safety Inspection Team Action Plan: On September 10, 2010, the Patient Safety Manager and the Readiness Coordinator met to determine who needed to be a part of the group participating in Mental Health Environment of Care Rounds

(MH EOC rounds). On September 15, 2010, a charge letter from the Acting Medical Center Director was composed, signed, and sent out to the nine individuals who would be participating in the MH EOC rounds. This letter stated that these individuals have been assigned to this group and participation is mandatory. All nine group members signed the Environment of Care Mental Health rounds forms on September 16, 2010, which verified their participation in the MH EOC rounds. The current staff on the inpatient mental health unit are being educated on the identification of hazards that pose a risk to suicidal patients. Training of all staff will be completed and documented by November 15, 2010. The new employee orientation list was updated to include education on the identification of hazards that pose a risk to suicidal patients. Annual results of the Environment of Care Mental Health rounds and staff education and training will be reported to the Environment of Care committee on a quarterly basis.

Recommendation 6. We recommended that nursing staff receive training on the required cleaning of glucometers.

Concur

Target date for completion: November 15, 2010

Glucometer Cleaning Action Plan: On September 3, 2010, initial staff education and training was initiated by posting flyers outlining the method and schedule for cleaning glucometers. The process for cleaning the glucometers outlines the need for glucometers to be cleaned with a 70% isopropyl alcohol pad after every patient. The flyers also state that staff must also disinfect the meter with a damp Cavi-Wipe disinfecting towelette daily, after using the meter on an isolation patient and when it is visibly soiled. An e-mail was sent to all nurse managers explaining the new glucometer cleaning requirements. All nursing staff will have documented training on the glucometer cleaning process by November 15, 2010.

Recommendation 7. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Target date for completion: March 30, 2011

Action Plan for Influenza Vaccinations: On September 30, 2010, an inpatient immunization template was implemented for seasonal influenza and high dose influenza documentation. This template includes a mandatory documentation data force field including the edition date of the Vaccine Information Statement (VIS), the date the VIS was provided, date of vaccine administration, vaccine manufacturer, the lot number of vaccine used, and the name and title of the person administering the vaccine. By October 30, 2010, all nurses will be educated on the documentation process. Handouts have been distributed to each staff nurse and posters are displayed at the nursing stations. For patients transferring to the Community Living Center (CLC) from the acute side of the hospital, a documentation field was inserted into the nursing discharge note to capture the patient's immunization status at the time of discharge. This will allow

CLC nurses to easily see their immunization status upon admission from the acute floors to CLC. Compliance with influenza documentation on the Community Living Centers (CLCs) will be monitored at the time of admission to CLC with direct feedback to staff. A monthly report will be submitted to Clinical Quality Council starting November 2010.

Recommendation 8. We recommended that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12 g/dL**.**

Concur

Target date for completion: December 1, 2010

ESA and Hemoglobin Level Action Plan: The required ESA template was implemented in August 2010. Quarterly template utilization data will be provided to P&T Committee for oversight/action beginning 1st Qtr FY11. By December 1, 2010, an ESA Clinic will be developed with an ESA Pharmacy Clinician to conduct clinic as well as to manage and monitor patients on ESA's. The majority of the prescriptions are written by four providers. These four providers were given explanations and handouts about the new template September 1, 2010. The facility's RN case manager was educated September 1, 2010, so she could be a resource to the providers. In order for the pharmacists to be educated, another pharmacist was brought in from another site in the VISN in August 2010 to provide education on the process prior to initiation of the template. This education was documented on an ESA template education sign in sheet.

Recommendation 9. We recommended that the pharmacy implement a consistent process for documenting retrospective review of all medication orders placed during the time the onsite pharmacy is not open.

Concur

Target date for completion: January 30, 2011

After Hours Pharmacy Operations Action Plan: On August 13, 2010, a documentation tool was developed in conjunction with Fargo and St. Cloud to document the daily review process for virtual Pharmacy finishing accuracy. On August 16, the documentation tool was implemented for conducting daily audits of overnight orders finished by the virtual Pharmacy. Immediate feedback for critical errors is handled daily. Monthly audits will be provided to the virtual pharmacy leadership starting October 2010, with August and September data being the baseline report. Reports will also be sent to Medication Safety Subcommittee quarterly to ensure compliance and over sight by 1st quarter 2011.

Recommendation 10. We recommended that the facility's medical record review process include monitoring the use of the "copy and paste" functions in the EMR.

Concur

Target date for completion: January 30, 2011

Action Plan: A facility copy and paste policy was developed as of July 30, 2010. Education has been provided at all Service Line Interdisciplinary meetings in the months of September and October. This will be completed as of October 15, 2010. The Clinical Application Coordinators (CAC's) also are providing education during new provider training. Monitoring of the copy and paste function in the medical record is currently being done retrospectively on a monthly basis by the HIMS Chief, and findings will be reported to the Chief of Staff and Service Line Leadership. Starting September 1, 2010, a monthly audit will be conducted to collect data on copying and pasting. Areas of non-compliance will be communicated with service line leadership and Chief of Staff. Quarterly executive summaries, including data and actions taken will be initiated starting January 2011.

Recommendation 11. We recommended that managers ensure that staff receive appropriate safety training prior to working in the MRI area.

Concur

Target date for completion: November 1, 2010

Action Plan: On August 27, 2010, the decision was made as to which staff would require annual MRI Level 1 Safety training. This list includes all staff that must perform duties in Zone 3 of the MRI Suite. This training includes a 15 minute MRI Safety video and an annual Employee MRI personal screening form. On August 27, 2010, MRI Level 1 Safety training and documentation was completed for 67 employees in the hospital. These individuals include staff from the following services: Radiology (Technical and Clerical), Nuclear Medicine (Technical and Clerical), Police, Housekeeping, Engineering, and Bio-Med. Level 2 MRI Safety training has been completed and documented for the four staff members who are allowed to enter Zone 4 by August 30, 2010. The MRI safety training and video has been added to the monthly New Employee Orientation agenda to capture all new employees starting November 1, 2010.

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