Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02188-15

Combined Assessment Program Review of the VA St. Louis Health Care System St. Louis, Missouri

October 29, 2012

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.

Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPRS	Computerized Patient Record System
CRC	colorectal cancer
DRRTP	Domiciliary Residential Rehabilitation Treatment Program
EHR	electronic health record
EMS	Environmental Management Services
EOC	environment of care
facility	VA St. Louis Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
OIG	Office of Inspector General
PIC	Performance Improvement Committee
POCT	point-of-care testing
QM	quality management
SA RRTP	Substance Abuse Residential Rehabilitation Treatment Program
SCI	spinal cord injury
TBI	traumatic brain injury
TMS	Talent Management System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA St. Louis Health Care System, St. Louis, MO

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 23, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following three activities:

- Colorectal Cancer Screening
- Medication Management
- Quality Management

The facility's reported accomplishments were leadership and structural changes and hosting the 2012 National Veterans Golden Age Games.

Recommendations: We made recommendations in the following seven activities:

Environment of Care: Ensure patient care areas are clean, well maintained, and safe. In the Mental Health Residential Rehabilitation Treatment Programs, update policies regarding medications and contraband, conduct and document self-inspections, and ensure female veteran occupied rooms are safe.

Moderate Sedation: Ensure all non-physician employees complete the required training program, include all required elements in pre-sedation assessment documentation, complete informed consents, and discharge patients appropriately.

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up within the required timeframes and are given follow-up mental health appointments prior to discharge.

Nurse Staffing: Ensure that the unit-based expert panel includes the required members and that all panel members receive the required training.

Polytrauma: Ensure patients with positive traumatic brain injury screening results receive comprehensive evaluations within the required timeframe, and provide treatment plans to patients and/or their families.

Point-of-Care Testing: Ensure staff can locate current manuals. Complete the action required in response to critical test results, and document the name of the provider notified.

Coordination of Care: Schedule follow-up appointments within the timeframes requested by providers or required by local policy.

Comments

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

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Objectives and Scope

Objectives

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

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

Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderation Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through July 27, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri,* Report No.11-01606-277, September 13, 2011).

During this review, we presented crime awareness briefings for 112 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 194 responded. We shared survey results with facility managers.

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

Leadership and Structural Changes

The facility has seen change in critical positions throughout all levels of the leadership structure. New members of the executive team include Deputy and Associate Directors, a Deputy Chief of Staff, and a Chief of Staff. In addition, there have been changes in service line leadership. These changes include new Chiefs of Medicine, Pulmonology, Neurology, SCI, Laboratory Medicine and Pathology, Psychiatry, Sterile Processing, and the Women Veterans Program. Leadership change has also occurred in many of the facility's inpatient nursing and outpatient clinic areas.

The facility has opened new and renovated areas to improve efficiency and quality of care. New areas include a state-of-the-art Sterile Processing Service, an SCI acute care unit at the John Cochran Division, an outpatient MH building, primary care clinic space, an improved renal dialysis center, and a radiology clinic and procedure area. The radiation oncology program has resumed, and the facility added another state-of-the-art magnetic resonance imaging machine.

Host of National Veterans Golden Age Games

The facility hosted the 26th National Veterans Golden Age Games May 31–June 5, 2012, and 787 veterans aged 55 and older from 40 states, the District of Columbia, and the U.S. Virgin Islands participated in the event. Hundreds of volunteers from the facility provided their time and talents to support the athletes, and the event was an unqualified success for both athletes and volunteers. The facility holds the sole distinction as the only medical facility in the nation to have hosted all three of VA's national events—the

National Veterans Wheelchair Games (in 2004), the National Veterans Creative Arts Festival (in 2007), and the National Veterans Golden Age Games.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's DRRTP and SA RRTP were in compliance with selected MH RRTP requirements.

We inspected inpatient units (CLC, medical, medical intensive care, MH, surgical, surgical intensive care, and SCI), the emergency department, and outpatient clinics (dental, MH, polytrauma, primary care, specialty care, and SCI). We also inspected the DRRTP and SA RRTP. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
X	Patient care areas were clean.
X	Fire safety requirements were met.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
X	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
X	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.

	Areas Reviewed for MH RRTP
X	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
X	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
X	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness and Infection Prevention. The Joint Commission requires the facility to maintain a clean environment and reduce the risk of infections. In 7 of the 16 clinical areas inspected, we found linen, equipment storage, supply, medication, inpatient, and exam rooms that were dirty and had holes in the walls.

Fire Safety. The National Fire Protection Association requires that Class K fire extinguishers are available where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats). The DRRTP has two kitchens that are used by residents, and no Class K fire extinguishers were available.

Environmental Safety. The Occupational Safety and Health Administration requires that oxygen tanks are stored upright and in a manner which distinguishes between empty and full tanks. We inspected oxygen storage areas in 11 patient care areas. In seven areas, oxygen tanks were not stored in a manner that distinguished between empty and full tanks.

Dental Clinic Laser Safety Training. Local policy requires that dental clinic employees who use or assist with laser procedures complete initial laser safety training. We reviewed four employee training records from the John Cochran division and determined that this training was not completed for any of the employees prior to the laser being used.

General Infection Control Practices at the Dental Clinic. The Occupational Safety and Health Administration requires that safety needle devices are readily available to minimize needle stick risk. The Jefferson Barracks dental clinic did not have safety needle devices.

MH RRTP Policy. VHA requires that MH RRTP managers develop a policy to safely manage medications and written procedures for detecting contraband brought onto the unit.[1] We found that the local medication policies and contraband procedures for the DRRTP and SA RRTP did not include all VHA requirements.

[1] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

MH RRTP Inspections. VHA requires facilities to conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy and to initiate appropriate corrective actions when deficiencies are identified.[2] DRRTP self-inspections were not completed for the past 6 months. SA RRTP self-inspections were not completed for 2 of the past 6 months, and documentation of completed inspections did not include all required elements. Additionally, there was no consistent documentation of corrective actions taken when deficiencies were identified.

VHA also requires facilities to inspect all MH RRTP residents' rooms daily to detect unsecured medications.[3] Although staff completed these inspections, we found unsecured medications in SA RRTP residents' rooms.

Safety Requirements for Women Veterans in MH RRTPs. VHA requires that MH RRTP rooms for female veterans are equipped with keyless entry or door locks to ensure safe, private, and secure sleeping and bathroom arrangements.[4] The SA RRTP had two female veterans residing on this mixed-gender unit in adjoining rooms with a shared bath. Safety, privacy, and security were jeopardized when one room was locked and the adjoining room was unlocked.

Recommendations

1. We recommended that the holes in the walls be repaired and that processes be strengthened to ensure that patient care areas are clean.

2. We recommended that the DRRTP have Class K fire extinguishers available in the kitchens used by residents.

3. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks.

4. We recommended that processes be strengthened to ensure that designated employees at the John Cochran dental clinic complete initial laser safety training and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that needle safety devices are available in the Jefferson Barracks dental clinic and that use of the devices be monitored.

6. We recommended that DRRTP and SA RRTP managers update the policies to safely manage medications and written procedures for contraband detection to include all VHA requirements and that compliance with the updated policies and procedures be monitored.

[2] VHA Handbook 1162.02.
[3] VHA Handbook 1162.02.
[4] VHA Handbook 1162.02 and VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

7. We recommended that processes be strengthened to ensure that monthly DRRTP and SA RRTP self-inspections are conducted and that documentation includes all required elements and corrective actions taken when deficiencies are identified.

8. We recommended that processes be strengthened to ensure that daily SA RRTP resident room inspections are thorough.

9. We recommended that processes be strengthened to ensure that SA RRTP rooms occupied by female veterans are safe, private, and secure.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 EHRs, and 103 training/competency records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
X	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
X	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Competency-Based Education/Training. VHA and local policy require employees to complete specific education prior to assisting with or providing moderate sedation.[5] Fourteen (14 percent) of the non-physician employees whose training records we reviewed had not completed the facility's required training program.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[6] Seven patients' EHRs did not include all required elements of the history and physical examination, such as a review of current medications, substance use or abuse, and an airway assessment.

Informed Consent. VHA requires that the patient be informed about the procedure and given the name of the provider who will perform the procedure.[7] One patient had no documented record of informed consent. For another patient, the provider who performed the procedure was not the same as the provider listed on the consent form,

[5] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[6] VHA Directive 2006-023.
[7] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.

and there was no evidence in the EHR that the change in provider was discussed with and agreed to by the patient.

Appropriate Discharge. VHA requires that moderate sedation outpatients be discharged in the company of a responsible, designated adult; discharged to lodging within the facility; or admitted as inpatients.[8] Two patients were unaccompanied at discharge.

Recommendations

10. We recommended that processes be strengthened to ensure that all non-physician employees complete the facility's required training program prior to assisting with or providing moderate sedation.

11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that informed consents are completed for all patients undergoing moderate sedation and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

13. We recommended that processes be strengthened to ensure that all moderate sedation outpatients are discharged in accordance with VHA requirements.

[8] VHA Directive 2006-023.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
X	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
X	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[9] Seven of the 20 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within 7 days of discharge. Additionally, three patients were contacted by telephone within 7 days of discharge but did not have an in-person or telemental health evaluation within 14 days.

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[10] Facility staff attempted to locate patients on the high risk for suicide list when they did not keep their scheduled appointments or were unable to be contacted via telephone. However, 6 of the 10 patients who were on the high risk for suicide list did not receive MH follow-up at the required intervals.

Follow-Up MH Appointments. VHA requires that patients discharged from inpatient MH be given follow-up MH appointments at the time of discharge.[11] Five patients (17 percent) did not have follow-up MH appointments scheduled prior to being discharged.

[9] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[10] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[11] VHA Handbook 1160.01.

Contact Attempts. VHA requires MH employees to document efforts to follow up with patients who do not keep scheduled MH appointments.[12] For four of the patients who failed to keep their scheduled MH appointments, we did not find documentation of follow-up attempts.

Recommendations

14. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at least weekly during the first 30 days after discharge and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that all patients discharged from inpatient MH receive follow-up MH appointments prior to being discharged.

17. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

[12] VHA Handbook 1160.01 and VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 26 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (6N) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
X	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
X	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Unit-Based Expert Panel Composition. VHA requires that unit-based expert panels include representatives from all nursing roles (registered nurse, licensed practical nurse, and nursing assistant).[13] Unit 6N's unit-based panel did not include a licensed practical nurse.

Expert Panel Member Training. VHA requires that all members of the facility and unit-based expert panels complete chapter 1 of the Staffing Methodology National Training.[14] We reviewed the training files of the facility panel members and unit 6N's panel members and found that none of the 26 members had completed the required training.

Variance Between Actual Nurse Staffing and Target. VHA requires that the facility's target nursing hours per patient day be used to plan for staffing and to evaluate actual staffing.[15] Unit 6N's average actual nursing hours per patient day were significantly below the target for the three groups of days reviewed.

Recommendations

18. We recommended that the annual staffing plan reassessment process ensure that unit 6N's unit-based expert panel includes representatives from all nursing roles.

[13] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
[14] VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.
[15] VHA Directive 2010-034.

19. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

20. We recommended that unit 6N's nurse managers reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, 10 outpatient EHRs, and 11 staff training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Timely Evaluation. VHA requires that patients with positive TBI screening results have a comprehensive TBI evaluation within 30 days of the positive screening.[16] Nine of the EHRs of patients with positive TBI results did not contain evidence that the patients were evaluated within 30 days.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed and that the plan be provided to the patient and/or their family.[17] Seven outpatient EHRs did not contain documentation that the plan was provided to the patient and/or the patient's family.

[16] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.
[17] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

Recommendations

21. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

22. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are provided to polytrauma outpatients and/or the patients' families.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
X	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Procedure Manual Availability. VHA requires that test methods and instruments have clearly written manuals available in each testing area.[18] Although current glucose POCT manuals were readily available electronically, none of the staff in the four patient care areas were aware of this, and no hard copies were available.

Test Results Management. When glucose values are determined to be critical, the facility requires that the employee performing the test document in the glucometer or EHR the name of the provider notified. For patients with chronic critical results, this action may not be necessary on every occasion as long as the known chronic result is documented. For 1 of the 10 patients who had critical test results, there was no

[18] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008.

documentation of provider notification. For seven of the remaining nine patients, there was no documentation of the name of the specific provider who was notified.

Recommendations

23. We recommended that processes be strengthened to ensure that staff in all testing areas are aware of the location of the current electronic glucose POCT manual.

24. We recommended that processes be strengthened to ensure that staff complete the action required in response to critical test results and document in the glucometer or EHR the name of the specific provider notified of the critical test results.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 28 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
X	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[19] In addition, local policy requires that HF patients discharged from an inpatient stay return within 14 days of their discharge dates. Although provider discharge instructions requested specific follow-up appointment timeframes, 14 appointments were either not scheduled as requested or were not scheduled within the timeframe required by local policy.

Recommendation

25. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

[19] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.

Review Activities Without Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[20] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[20] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed (continued)
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 27–36 for the full text of the Directors' comments.) We consider Recommendations 2 and 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[21]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	15	
Community Based Outpatient Clinics	Belleview, IL Florissant, MO O'Fallon, MO Washington, MO	
Veteran Population in Catchment Area	234,931	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	210	
• **CLC/Nursing Home Care Unit**	71	
• **Other**	75 domiciliary	
Medical School Affiliation(s)	St. Louis University Washington University	
• **Number of Residents**	126.5	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$394	$409
• **Medical Care Expenditures**	$202	$409
Total Medical Care Full-Time Employee Equivalents	2,386.8	2,357.6
Workload:		
• **Number of Station Level Unique Patients**	44,573	58,684
• **Inpatient Days of Care:**		
o **Acute Care**	34,515	76,238
o **CLC/Nursing Home Care Unit**	9,996	22,323
Hospital Discharges	5,024	10,774
Total Average Daily Census (including all bed types)	243	270
Cumulative Occupancy Rate (in percent)	68	76
Outpatient Visits	295,131	621,091

[21] All data provided by facility management.

VHA Satisfaction Surveys

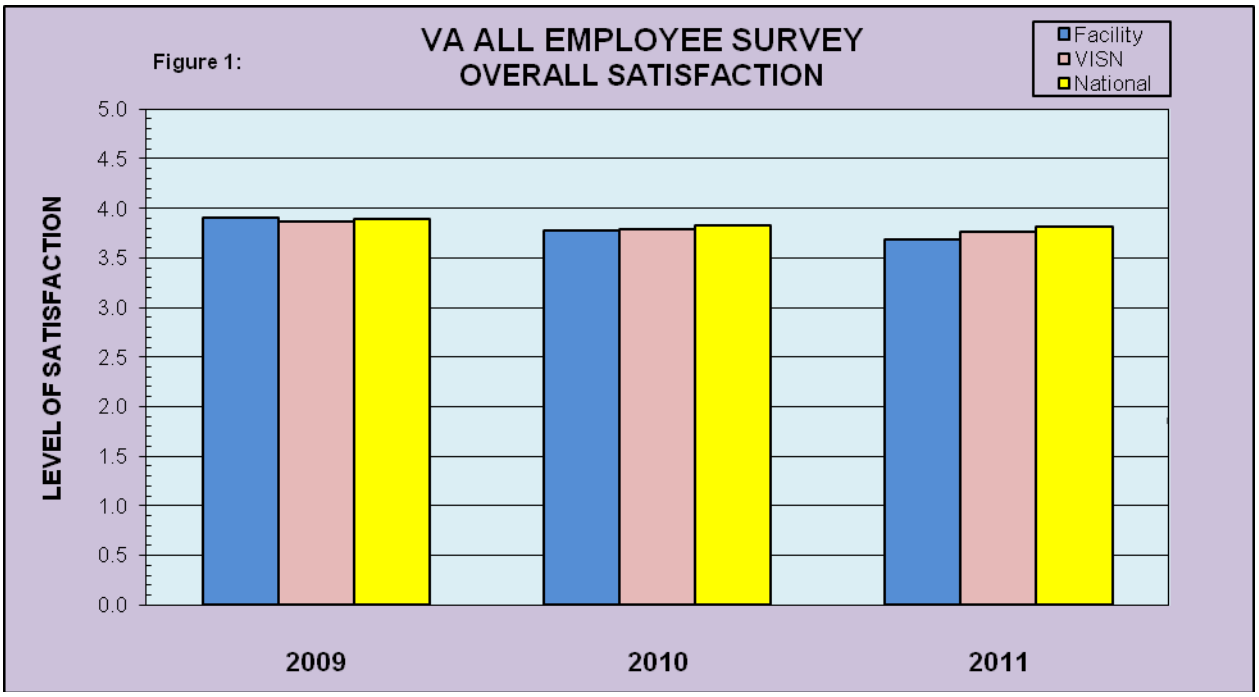
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	38.1	44.0	44.1	44.4	50.9	47.7
VISN	57.8	56.8	52.2	51.7	53.0	55.0
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[22] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[23]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	12.2	9.8	11.2	23.2	29.0	21.0
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[22] A heart attack occurs 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 timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[23] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2012

From: Director, VISN 15 (10N15)

Subject: **CAP Review of the VA St . Louis Health Care System, St. Louis, MO**

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

Director, Management Review Service (VHA 10AR MRS)

Attached, please find the response for the Combined Assessment Program Review of the St. Louis VA Medical Center St. Louis, Missouri.

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused towards continuous performance improvement.

For additional questions please feel free to contact Jimmie Bates, VISN 15 Quality Management Officer at 816-701-3014.

(original signed by:)
William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2012

From: Director, VA St. Louis Health Care System (657/00)

Subject: **CAP Review of the VA St . Louis Health Care S ystem, St. Louis, MO**

To: VISN Director (10N15)

I have reviewed the findings within the report of the Combined Assessment Program Review of the St. Louis VA Health Care System. I am in agreement with the findings of the review.

Corrective actions plans have been established with planned completion dates as outlined in this report.

(original signed by:)
Rimaann O. Nelson RN MHA/HSA

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the holes in the walls be repaired and that processes be strengthened to ensure that patient care areas are clean.

Concur

Target date for completion: July 31, 2012

The holes in the walls identified during the OIG inspection were repaired in the linen, supply, equipment storage, and medication rooms by engineering staff. An inspection was conducted by the Chief Engineer with appropriate engineering staff to identify and repair any other damaged walls. The Chief, EMS, assigned staff to clean areas identified on OIG inspection. Medication, linen, supply, and equipment storage areas were added to the daily EMS inspection checklist. The EMS supervisor will inspect the areas once per week. The Chief, EMS and EMS Foreman will inspect at least 10 percent of the EMS supervisor's inspections to verify the accuracy of inspection and abatement of the findings.

Recommendation 2. We recommended that the DRRTP have Class K fire extinguishers available in the kitchens used by residents.

Concur

Target date for completion: July 31, 2012

Class K extinguishers were purchased and installed at the DRRTP kitchens.

Recommendation 3. We recommended that processes be strengthened to ensure that oxygen tanks are stored in a manner that distinguishes between empty and full tanks.

Concur

Target date for completion: October 15, 2012

The Safety Manager will review each location where the oxygen tanks are stored to identify areas and tools for full and empty tanks.

Recommendation 4. We recommended that processes be strengthened to ensure that designated employees at the John Cochran dental clinic complete initial laser safety training and that compliance be monitored.

Concur

Target date for completion: July 31, 2012

Designated Dental Service employees completed laser safety training. The Chief, Dental Service, will monitor compliance with training and report to Laser Safety Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that needle safety devices are available in the Jefferson Barracks dental clinic and that use of the devices be monitored.

Concur

Target date for completion: July 31, 2012

The Chief, Dental Service, added needle safety devices to supply inventory. Jefferson Barracks Dental staff was educated on the availability and use.

Recommendation 6. We recommended that that DRRTP and SA RRTP managers update the policies to safely manage medications and written procedures for contraband detection to include all VHA requirements and that compliance with the updated policies and procedures be monitored.

Concur

Target date for completion: October 30, 2012

DRRTP and SA RRTP standard operating procedures for medication management and contraband were revised to reflect all VHA requirements. DRRTP and SA RRTP Program Managers will monitor compliance through self-inspections.

Recommendation 7. We recommended that processes be strengthened to ensure that monthly DRRTP and SA RRTP self-inspections are conducted and that documentation includes all required elements and corrective actions taken when deficiencies are identified.

Concur

Target date for completion: October 30, 2012

The self-inspection checklist was revised to include all required elements. DRRTP and SA RRTP Program Managers will ensure that monthly inspections are completed,

corrective actions taken when deficiencies are identified, and submit the report to the EOC Committee and MH Executive Council quarterly.

Recommendation 8. We recommended that processes be strengthened to ensure that daily SA RRTP resident room inspections are thorough.

Concur

Target date for completion: October 30, 2012

Daily SA RRTP resident room inspection checklist was reviewed and revised to include all required elements. SA RRTP Program Manager will ensure that daily inspections are completed and corrective actions taken. The SA RRTP Program Manager will submit the monthly report to the MH Executive Council.

Recommendation 9. We recommended that processes be strengthened to ensure that SA RRTP rooms occupied by female veterans are safe, private, and secure.

Concur

Target date for completion: October 15, 2012

Locks on the designated female Veteran rooms have been changed to secure each room individually and not allow access via the shared bathroom to the other designated female room.

Recommendation 10. We recommended that processes be strengthened to ensure that all non-physician employees complete the facility's required training program prior to assisting with or providing moderate sedation.

Concur

Target date for completion: July 30, 2012

All designated staff completed required moderate sedation training. The Designated Learning Officer will produce a monthly compliance training report and distribute to the designated managers/supervisors. Staff who are not current with training will not be allowed to participate in moderate sedation.

Recommendation 11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that compliance be monitored.

Concur

Target date for completion: November 30, 2012

A standard CPRS template will be developed and implemented to ensure that all pre-sedation assessment documentation is captured in a consisted manner. Once

Medical Records Review Committee approval is obtained, the template will be required of all locations utilizing moderate sedation. Compliance will be monitored and reported to the PIC.

Recommendation 12. We recommended that processes be strengthened to ensure that informed consents are completed for all patients undergoing moderate sedation and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

Concur

Target date for completion: October 1, 2012

The service chief re-educated providers with sedation privileges on informed consent requirements and changes to consents are discussed and recorded prior to the administration of sedations. Compliance will be monitored and reported to the PIC.

Recommendation 13. We recommended that processes be strengthened to ensure that all moderate sedation outpatients are discharged in accordance with VHA requirements.

Concur

Target date for completion: November 30, 2012

A standard CPRS template will be developed and implemented to ensure that all post-assessment and discharge documentation is captured in a consisted manner. Once Medical Records Review Committee approval is obtained, the template will be required of all locations utilizing moderate sedation. Compliance will be monitored and reported to the PIC.

Recommendation 14. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

Concur

Target date for completion: October 1, 2012

Capacity in MH clinics has been expanded by recently hiring psychiatrists, psychologists, and MH social workers. A walk-in clinic was established at John Cochran Division to add additional same day MH access. Daily audits of discharge patients are being conducted to ensure Veterans have a scheduled appointment within 7 days of discharge. Designated staff have been assigned responsibility to make telephone contact with discharged Veterans within 48 hours of discharge to re-enforce and remind Veteran of the scheduled follow-up appointment. Performance will be monitored through the Leadership Performance Advisory Board.

Recommendation 15. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at least weekly during the first 30 days after discharge and that compliance be monitored.

Concur

Target date for completion: October 1, 2012

Veterans identified as high risk are entered on spreadsheet maintained by Suicide Prevention. The Suicide Prevention staff will ensure that Veterans are assigned to a psychiatrist for follow-up. The psychiatrist and team's social worker or psychiatrist will provide daily communication on completion of follow-up contacts. Veterans who were not reached by the MH team will receive assistance from the suicide prevention team. Performance will be monitored by the Associate Chief of Staff for MH.

Recommendation 16. We recommended that processes be strengthened to ensure that all patients discharged from inpatient MH receive follow-up MH appointments prior to being discharged.

Concur

Target date for completion: October 1, 2012

For planned discharges, the Acute Psychiatry team leaders will review the 7-day follow-up spreadsheet daily and verify that all patients discharged within the previous 24 hours have a scheduled MH health appointment. The team leaders will also verify that the patient's follow-up MH appointment falls within 7 days of discharge. For patients who are discharged without a scheduled MH appointment, the Acute Inpatient Psychiatry team leaders will notify the appropriate outpatient treatment team and inform them that a patient belonging to their treatment team has been discharged and is in need of a follow-up appointment. The outpatient treatment team will then be responsible for contacting the patient to schedule an outpatient appointment. For Against Medical Advice discharges, the charge nurse will notify the Administrative Officer of the Day regarding the patient's discharge and request that the Administrative Officer of the Day schedule the patient for the next scheduled MH DIGMA (drop in group medical appointment). Prior to the patient leaving the acute psychiatry unit, the charge nurse will complete an appointment reminder sheet. The charge nurse will attach the completed reminder sheet to the patient's discharge paperwork. Performance will be monitored by the Associate Chief of Staff for MH.

Recommendation 17. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance be monitored.

Concur

Target date for completion: October 31, 2012

Clinical staff were re-educated on the MH Service policy on follow-up of No Shows. In morning huddle in each MH clinic, the team will review all No Shows of these patients to ensure active follow-up. Monthly audit to ensure documentation of follow-up attempts has occurred. Performance will be monitored by the Associate Chief of Staff for MH.

Recommendation 18. We recommended that the annual staffing plan reassessment process ensure that unit 6N's unit-based expert panel includes representatives from all nursing roles.

Concur

Target date for completion: September 22, 2012

The 6 North unit-based expert panel was expanded to include all nursing roles. Two registered nurses, two nursing assistants, and the nurse manager were added.

Recommendation 19. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: September 22, 2012

All members of the facility and unit-based expert panels completed the required training. The Designated Learning Officer generated a TMS training report to verify completion and reported to Associate Director Patient Care Services and Clinical Executive Board.

Recommendation 20. We recommended that unit 6N's nurse managers reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: September 22, 2012

6 North completed a reassessment to evaluate the actual staffing provided and adjusted a staffing plan accordingly. Associate Chief Nurse for Inpatient Surgical Service will monitor actual staffing as compared to staffing plan.

Recommendation 21. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

Concur

Target date for completion: November 30, 2012

Capacity to complete TBI evaluations within 30 days was increased by the filling of vacant physiatrist positions. Positions were filled at the time of the inspection with staff entrance on duty dates established. Compliance with timeliness is monitored by the Chief, Physical Medicine and Rehabilitation.

Recommendation 22. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are provided to polytrauma outpatients and/or the patients' families.

Concur

Target date for completion: July 31, 2012

The interdisciplinary treatment plan template was reviewed and revised to include documentation of the plan being provided to the patient and/or family. The individual's care plan is entered by the case manager and provided to the Veteran and/or family verbally and written. The team member reviewing care plan with the Veteran and/or family documents the discussion in CPRS.

Recommendation 23. We recommended that processes be strengthened to ensure that staff in all testing areas are aware of the location of the current electronic glucose POCT manual.

Concur

Target date for completion: November 30, 2012

A link to the electronic glucose POCT manual in was added to the nursing policy home page for easier access. This addition was communicated via email to all users. Self Certification will be obtained for all glucometer operators via TMS. Ancillary Testing Coordinator will monitor completion and report completion rates to nursing leadership.

Recommendation 24. We recommended that processes be strengthened to ensure that staff complete the action required in response to critical test results and document in the glucometer or EHR the name of the specific provider notified of the critical test results.

Concur

Target date for completion: November 30, 2012

A CPRS template will be developed and implemented upon approval by Medical Records Review Committee to document the action taken for a critical test result to include the specific provider notified of the critical test result. Staff will be trained on new template. Training completion will be monitored by the Ancillary Testing Coordinator via a TMS training report. The Ancillary Testing Coordinator will monitor compliance with documentation of all required elements in reporting critical values. Nursing leadership will be informed and take action on any noncompliance identified.

Recommendation 25. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers or required by local policy.

Concur

Target date for completion: October 31, 2012

The Acting Chief, Medicine Service established new standard operating procedures to involve the congestive HF case managers in establishing follow-up appointments prior to discharge with a Primary Care or Cardiology Provider. Timeframe for follow-up appointment will be determine by the inpatient medicine team. Compliance will be monitored and reported to the Associate Chief of Staff for Medicine and Primary Care.

OIG Contact and Staff Acknowledgments

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