Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03650-53

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

January 29, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CPR	cardiopulmonary resuscitation
EHR	electronic health record
EOC	environment of care
facility	Harry S. Truman Memorial Veterans' Hospital
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VJO	Veterans Justice Outreach

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 11, 2013.

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

- Coordination of Care
- Medication Management
- Nurse Staffing

The facility's reported accomplishments were the Veterans Justice Outreach Program and the expansion of gastroenterology services.

Recommendations: We made recommendations in the following four activities:

Quality Management: Reconsider Peer Review Committee membership to ensure sufficient experienced senior physicians are regular members. Ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely. Require that Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. Ensure the Surgical Work Group meets monthly and includes the Chief of Staff as a member. Keep the recipient list for the automated e-mail notification for the critical incidents reporting process current. Review the quality of entries in the electronic health record at least quarterly, and include most services in the review of electronic health record quality. Ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings and that the blood/transfusions usage review process includes the results by government or private (peer) entities and the results of peer reviews when transfusions did not meet criteria.

Environment of Care: Ensure the locked mental health unit nursing station has a panic alarm system.

Pressure Ulcer Prevention and Management: Accurately document risk scale scores for all patients with pressure ulcers. Perform and document daily risk scales, and revise prevention plans when risk levels change for patients at risk for or with pressure ulcers. Develop interprofessional treatment plans for all hospitalized patients identified as being at risk for pressure ulcers and patients with pressure ulcers, and provide and document recommended interventions. Provide and document pressure ulcer education for

patients at risk for and with pressure ulcers and/or their caregivers. Complete applicable consults for patients at risk for and with pressure ulcers.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Document resident progress towards restorative nursing goals. Document the reasons for discontinuing or not providing restorative nursing services when these services are care planned. Provide all care planned/ordered assistive eating devices to residents for use during meals. Document resident progress using the required Restorative Weekly Note.

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. (See Appendixes C and D, pages 20–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2013 and FY 2014 through November 15, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri,* Report No. 10-00879-126, April 8, 2010).

During this review, we presented crime awareness briefings for 159 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 142 responded. We shared summarized 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

VJO Program

The purpose of the VJO program is to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by ensuring that eligible justice-involved veterans have timely access to VHA services as clinically indicated. In 2013, the facility VJO program established Veteran Treatment Courts in local counties and formed a Veteran Legal Clinic, which is held weekly at the facility. Facility VJO staff are on the Special Veteran Committee with the Missouri Bar Association and are working to establish Veteran Legal Clinics across Missouri. Facility VJO program staff also provided veteran program education to local law enforcement officers and implemented a telemedicine anger management group, which is offered to veterans at the facility and its community based outpatient clinics.

Gastroenterology Service Expansion

In 2013, the facility expanded gastroenterology services by opening a fourth, fully staffed procedure room; acquiring image equipment for endoscopy and bronchoscopy procedures; and initiating capsule endoscopies.[a] Facility providers are now able to perform more endoscopy procedures than prior to the expansion, and the ability to perform capsule endoscopy has resulted in a $5,000 per month savings (based on an average of 5 capsule endoscopies per month) and improved patient continuity of care because the results are immediately available in the EHR to ordering providers.

[a] A tiny capsule the size of a large pill that is swallowed and takes pictures of the small intestine.

Results and Recommendations

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 met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twelve months of PRC meeting minutes reviewed: • Although PRC membership included staff physicians, it did not include the expected experienced senior physicians, such as the Chiefs of Primary Care and MH.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	Eight months of data reviewed: • For February–September 2013, 40 percent of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization during that time.
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Four quarters of CPR Committee meeting minutes reviewed: • There was no evidence that code reviews included screening for clinical issues prior to the code that may have contributed to the occurrence of the code.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The OR Committee (the Surgical Work Group) only met 7 times over the past 9 months. Seven months of OR Committee meeting minutes reviewed: • The Chief of Staff was not a member.
X	Critical incidents reporting processes were appropriate.	• The recipient list for the automatic e-mail notification was not current.
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Twelve months of the Health Information Committee meeting minutes reviewed: • EHR quality data was analyzed for only 2 quarters. • The review of EHR quality did not include EHRs from MH and Pharmacy Services.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Blood Usage Review Committee meeting minutes reviewed: • A clinical representative from Anesthesia Service attended only two of four meetings. • The review process did not include the results of inspections by government or private (peer) entities and the results of peer reviews when transfusions did not meet criteria.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the Chief of Staff reconsider PRC membership to ensure that sufficient experienced senior physicians are regular members.

2. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

3. We recommended that processes be strengthened to ensure that CPR Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

4. We recommended that the OR Committee (the Surgical Work Group) meet monthly and include the Chief of Staff as a member.

5. We recommended that processes be strengthened to ensure that the recipient list for the automated e-mail notification for critical incidents is kept current.

6. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly and that the review of EHR quality includes most services.

7. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings and that the blood/transfusions usage review process includes the results of inspections by government or private (peer) entities and the results of peer reviews when transfusions did not meet criteria.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected inpatient units (acute MH, CLC, intensive care, medical, and surgical), outpatient areas/clinics (x-ray and fluoroscopy, primary care, and specialty care), and the emergency department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
X	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	• The nursing station did not have a panic alarm system that ensured emergent response by staff and VA police.

NM	Areas Reviewed for Acute MH (continued)	Findings
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

8. We recommended that the locked MH unit nursing station have a panic alarm system.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 34 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 25 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 28 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 3 randomly selected units—acute medical/surgical unit 4B, CLC unit 3 East, and MH unit 2B—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The 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 VHA or local policy.	

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 21 EHRs of patients with pressure ulcers (8 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 3 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 12 of the 21 EHRs, staff did not consistently document the risk scale score.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• Four of the 20 applicable EHRs did not contain consistent documentation that staff performed daily risk scales and/or revised prevention plans when risk level changed.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
X	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	• Five of the 21 EHRs contained no documentation that interprofessional treatment plans were developed and/or did not reflect that interventions were provided.
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 14 of the 18 applicable patients at risk for or with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policy on assessment and prevention of pressure ulcers reviewed: • In 5 of the 21 EHRs, applicable consults were not completed.

Recommendations

9. We recommended that processes be strengthened to ensure that acute care staff accurately document risk scale scores for all patients with pressure ulcers and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales and revise prevention plans when risk levels change for patients at risk for or with pressure ulcers and that compliance be monitored.

11. We recommended that processes be strengthened to ensure that acute care staff develop interprofessional treatment plans for all hospitalized patients identified as being at risk for pressure ulcers and patients with pressure ulcers and that staff provide and document recommended interventions and that compliance be monitored.

12. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

13. We recommended that processes be strengthened to ensure that applicable consults are completed for patients at risk for and with pressure ulcers and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 12 EHRs of residents (10 residents receiving restorative nursing services and 2 residents not receiving restorative nursing services but candidates for services). We also observed 10 residents during 2 meal periods, reviewed 5 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 9 of the 10 applicable EHRs, there was no documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• None of the 9 applicable EHRs contained evidence that facility staff documented resident progress towards restorative nursing goals.
X	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	• In the two EHRs where restorative nursing services were care planned but were not provided or were discontinued, there were no reasons documented.
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
X	Care planned/ordered assistive eating devices were provided to residents at meal times.	• Six of the 36 assistive eating devices care planned/ordered (17 percent) were not provided to residents.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	Required activities were performed during resident meal periods.	
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on rehabilitative/restorative and supportive nursing care for extended care residents reviewed: • None of the 9 applicable EHRs contained ongoing documentation regarding resident progress using the required Restorative Weekly Note.

Recommendations

14. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

15. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

16. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

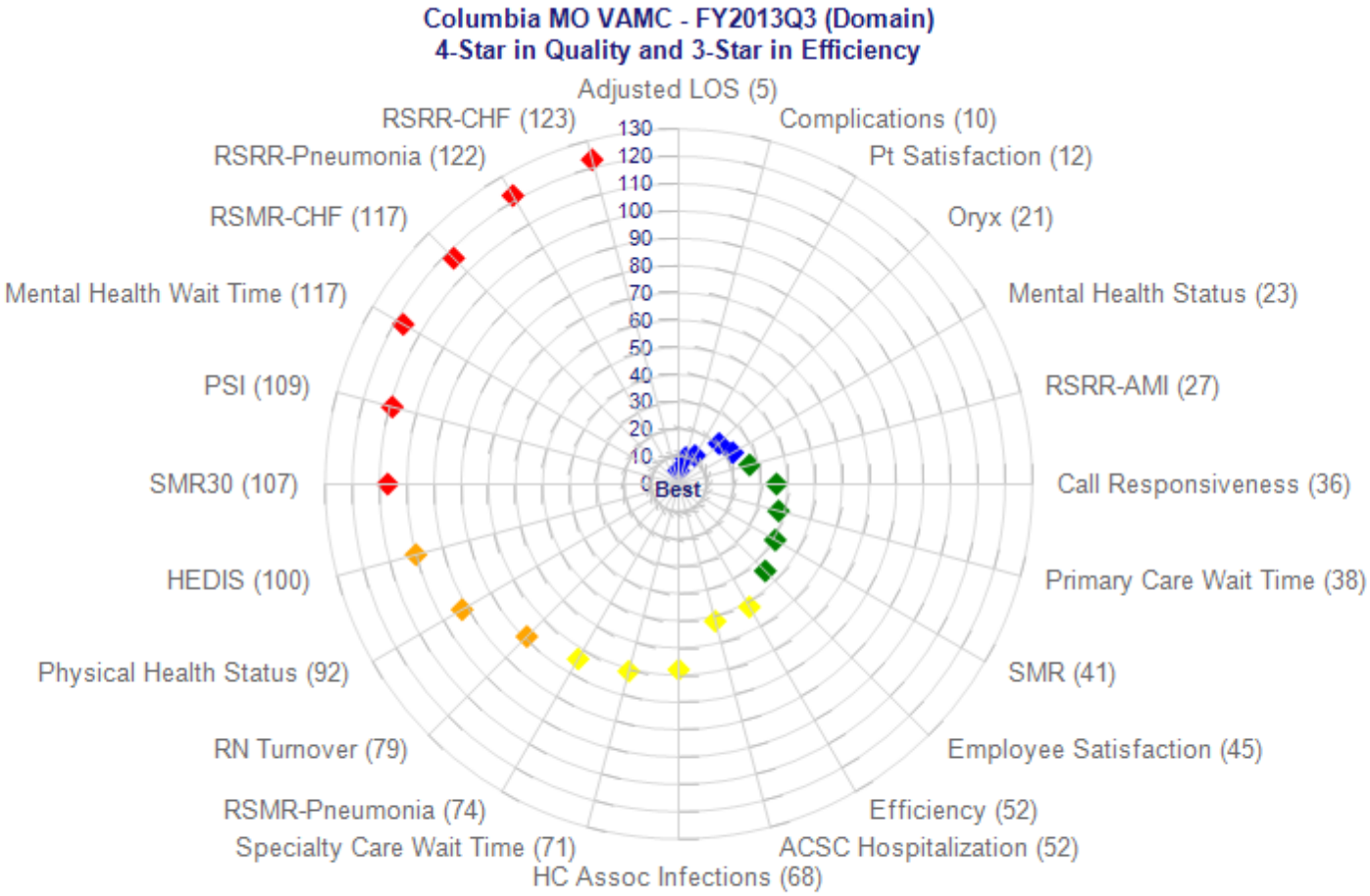
17. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

18. We recommended that processes be strengthened to ensure that staff document resident progress using the required Restorative Weekly Note.

Facility Profile (Columbia/589) FY 2014 through December 2013[b]	
Type of Organization	Tertiary
Complexity Level	1C-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$269.7
Number of:	
• **Unique Patients**	22,056
• **Outpatient Visits**	78,922
• **Unique Employees**[c]	1,039
Type and Number of Operating Beds (October 2013):	
• **Hospital**	74
• **CLC**	41
• **MH**	12
Average Daily Census (November 2013):	
• **Hospital**	43
• **CLC**	32
• **MH**	5
Number of Community Based Outpatient Clinics	7
Location(s)/Station Number(s)	Jefferson City/589G8 Kirksville/589GE Ft. Leonard Wood/589GF Lake of the Ozarks/589GH Mexico/589GX St. James/589GY Sedalia/589JA
VISN Number	15

[b] All data is for FY 2014 through December 2013 except where noted.
[c] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

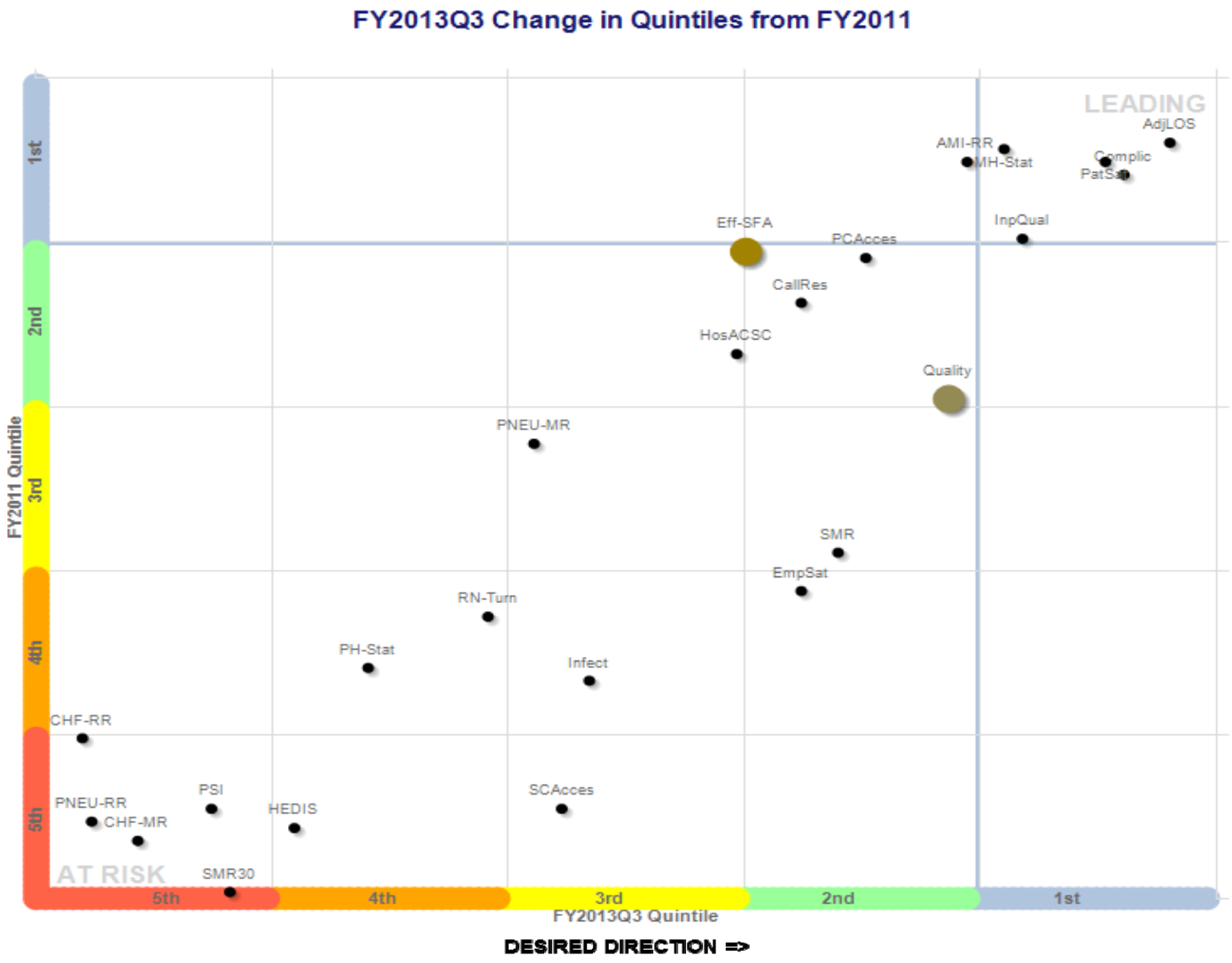
Strategic Analytics for Improvement and Learning (SAIL)[d]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[d] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 30, 2013

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Attached please find Truman VA's response to the draft report of the Combined Assessment Program Review conducted the week of November 11, 2013.

2. I have reviewed and concur with the Acting Medical Center Director's response and proposed action plans.

3. If you have any questions, please feel free to contact Julie Madere, Acting VISN 15 Quality Management Officer at 816-701-3000.

WILLIAM P. PATTERSON, MD, MSS

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 26, 2013

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

Subject: **CAP Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO**

To: Director, VA Heartland Network (10N15)

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of Inspector General Combined Assessment Program Review conducted the week of November 11, 2013.

2. Corrective action plans have been developed or implemented for all recommendations as outlined in the attached report.

ROBERT G. RITTER, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Chief of Staff reconsider PRC membership to ensure that sufficient experienced senior physicians are regular members.

Concur

Target date for completion: January 14, 2014

Facility response: The Peer Review Board policy was revised on December 10, 2013 to reflect a change in membership from at least three direct patient care physicians to at least three senior members of the medical staff. The first meeting with the new membership will be January 14, 2014.

Recommendation 2. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

Concur

Target date for completion: December 12, 2013

Facility response: Observation criteria and utilization are being discussed at the quarterly Physician Utilization Management Advisor meeting with clinical reviewers. These discussions are now being documented in minutes. Discussions were also occurring at Clinical Executive Board (CEB) when conversions from observation bed status to acute admissions were over 30 percent; however, these discussions were not documented in the minutes. All future discussions will be documented in detail in the CEB minutes. The Chief of Quality Management will review the minutes for 6 months to ensure appropriate documentation of the discussions is occurring.

Recommendation 3. We recommended that processes be strengthened to ensure that CPR Committee code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code.

Concur

Target date for completion: February 28, 2014

Facility response: A database is being developed that will be used to enter the data from the code reviews as they are completed, to include screening for clinical issues

prior to the code. Reports will be generated from the database and the results discussed and documented in CPR Committee minutes. Until the database is completed and tested, a code blue review checklist will be used to document review of the codes. Findings from the reviews will be discussed at the CPR Committee and documented in the minutes. The Chief of Quality Management will review the minutes for 6 months to ensure appropriate review and documentation is occurring.

Recommendation 4. We recommended that the OR Committee (the Surgical Work Group) meet monthly and include the Chief of Staff as a member.

Concur

Target date for completion: January 31, 2014

Facility response: The Surgical Work Group (previously OR Committee) policy is currently being revised to include the Chief of Staff as a member of the committee. The Chief of Staff did attend the December 10, 2013, meeting. The revised policy will also include the requirement that the committee meet monthly.

Recommendation 5. We recommended that processes be strengthened to ensure that the recipient list for the automated e-mail notification for critical incidents is kept current.

Concur

Target date for completion: November 20, 2013

Facility response: The Critical Incident Tracking Notification (CITN) system was updated on November 20, 2013, to reflect the current Acting Chief Medical Officer. All other recipients are current. Our process has been changed to include verification that the recipient list is current prior to submission of any critical incidents.

Recommendation 6. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly and that the review of EHR quality includes most services.

Concur

Target date for completion: January 31, 2014

Facility response: Health Information Committee has developed a reporting matrix for review of the quality of entries in the EHR. This matrix includes all services with staff who document in the EHR. Reviews are scheduled for each quarter to ensure data is collected and analyzed at least quarterly. The Chief of Quality Management will review minutes of the Health Information Committee for 4 quarters to ensure compliance.

Recommendation 7. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Anesthesia Service consistently attends meetings and that the blood/transfusions usage review process includes the results of inspections by government or private (peer) entities and the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: January 31, 2014

Facility response: The Chief of Staff addressed attendance at the Blood Usage Review Committee prior to this site visit, and attendance at the last 2 quarterly meetings met the criteria. The Chair of the Blood Usage Review Committee reviewed VHA Directive 2009-005 for required elements and has added the results of inspections and results of peer reviews as standing agenda items for future committee meetings. These discussions will be documented in the minutes. The Chief of Quality Management will review the minutes of the Blood Usage Review Committee for 6 months to ensure compliance with attendance and required reviews.

Recommendation 8. We recommended that the locked MH unit nursing station have a panic alarm system.

Concur

Target date for completion: January 31, 2014

Facility response: The nurse locator system is used as our panic alarm system. When activated it notifies the nursing staff at the unit nursing station as well as the telephone operator. All staff assist alarms from 2B (mental health unit) are considered a Code Orange (behavior emergency) and operators call a Code Orange to 2B. A process has been implemented for testing of the locator badges and documentation of the testing. The 2B Nurse Manager will provide training to all staff on the testing procedure.

Recommendation 9. We recommended that processes be strengthened to ensure that acute care staff accurately document risk scale scores for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: Education will be provided to nursing staff as part of the annual competency and during nursing orientation. The Skin/Wound Registered Nurse (RN) will provide education to off tour nursing staff on the Braden scale. Skin Resource Nurses will provide quarterly inservices on the Braden Scale to their respective units. Nurse managers, in collaboration with the Skin/Wound RN, will perform monthly random chart audits for appropriate and consistent Braden scoring using a standardized audit tool. Nurse managers will identify trends and address concerns with staff individually as

needed. Random chart reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 10. We recommended that processes be strengthened to ensure that acute care staff perform and document daily risk scales and revise prevention plans when risk levels change for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: Office of Information Technology (OIT) has inactivated the CO-Nursing Note Template, which does not have the VA Nursing Outcomes Database skin template included, to ensure correct documentation in the correct template. In addition to the annual competency, all inpatient and CLC RNs will be required to view the educational DVD, "The Big 4 in Under 4." This DVD presents how to complete a skin assessment in 4 minutes. Education will be documented in Talent Management System. Nurse managers, in collaboration with the Skin/Wound RN, will perform monthly random chart audits for daily skin assessment and correct note template using a standardized audit tool. Random chart reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 11. We recommended that processes be strengthened to ensure that acute care staff develop interprofessional treatment plans for all hospitalized patients identified as being at risk for pressure ulcers and patients with pressure ulcers and that staff provide and document recommended interventions and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: OIT will build an option for automatic Wound Care Nurse consult into documentation to be included in all reassessment, admission and transfer nursing notes. This will include a prompt that a consult is needed on any pressure ulcer and Braden score less than 12 as per hospital policy.

OIT will also build an option for automatic consults for the dietician into documentation templates (as above). This will include a prompt to do a consult to the dietitian for any patient with a Braden score less than 16 as stated in hospital policy.

The Skin/Wound RN and/or unit Skin Resource Nurses will consult additional disciplines as needed when the skin/wound consult is completed. Automatic consult option will be added to the CO-Skin Integrity Evaluation and Consult notes (Occupational Therapy, Physical Therapy, Social Work, Prosthetics).

OIT will remove the option to select "no interventions needed" so addition of appropriate interventions will be a mandatory documentation field.

Nurse managers, in collaboration with the Skin/Wound RN, will perform monthly random chart audits using a standardized audit tool. Reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months. Trends identified by the audit tool will be discussed at monthly Skin Resource Nurse meetings and action plans created as needed.

Recommendation 12. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: The Skin/Wound RN and the Skin Resource Nurses will develop an educational template to be added by OIT with mandatory fields in all nursing documentation including admission assessment, transfer note, reassessment notes and discharge note. An educational pamphlet has been made available on every unit in a prominent location.

Nurse managers, in collaboration with the Skin/Wound RN, will perform monthly random chart audits for documentation of education using a standardized audit tool. Reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 13. We recommended that processes be strengthened to ensure that applicable consults are completed for patients at risk for and with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: OIT will build an option for automatic Wound Care Nurse consult into documentation to be included in all reassessment, admission and transfer nursing notes. This will include a prompt that a consult is needed on any pressure ulcer and Braden score less than 12 as per hospital policy.

OIT will also build an option for automatic consults for the dietician into documentation templates (as above). This will include a prompt to do a consult to the dietitian for any patient with a Braden score less than 16 as stated in hospital policy.

Skin/Wound RN, in collaboration with the nurse managers, will monitor trends monthly. Chart reviews will begin in February 2014 and continue until 90 percent compliance is

achieved for 3 months. Nurse managers will follow up on individual documentation issues and failure to follow policy.

Recommendation 14. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: CLC staff was in-serviced on documentation of restorative nursing services according to clinician orders and/or residents' care plans. Documentation will be completed by facility staff. The CLC Nurse Manager or designee will conduct a monthly random audit to ensure restorative nursing services are documented according to clinical orders and/or residents' care plans. Reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 15. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: CLC staff was in-serviced on documentation of progress towards restorative nursing goals. Staff nurses will document weekly resident progress towards restorative nursing goals. The CLC Nurse Manager or designee will conduct a monthly random audit to ensure that staff document resident progress towards restorative goals. Reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 16. We recommended that processes be strengthened to ensure that staff document the reasons for discontinuing or not providing restorative nursing services when those services are care planned and that compliance be monitored.

Concur

Target date for completion: January 31, 2014

Facility response: CLC staff was in-serviced on documenting in the EHR the reasons for discontinuing or not providing restorative nursing services when these services are care planned. When restorative nursing services are care planned but not provided or discontinued reasons will be documented in the EHR. The CLC Nurse Manager or designee will conduct a monthly audit of records to ensure appropriate documentation is occurring. Reviews will begin in February 2014 and continue until 90 percent compliance is achieved for 3 months.

Recommendation 17. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: December 31, 2013

Facility response: The list of ordered/care planned assistive eating devices was updated on November 21, 2013. In addition to entering the order into Vista when a new type of adaptive equipment is ordered for a resident, the CLC dietitian is sending an additional note to the kitchen as a reminder. The Nutrition and Food Service staff was reminded at the November staff meeting to double check the patient tray tickets to ensure that the ordered assistive eating devices are on the resident trays. The dietitian and supervisors of Nutrition and Food Service will monitor one breakfast, lunch and dinner weekly for assistive eating devices being provided. The audits will continue until 90 percent compliance is achieved for 3 months.

Recommendation 18. We recommended that processes be strengthened to ensure that staff document resident progress using the required Restorative Weekly Note.

Concur

Target date for completion: November 29, 2013

Facility response: CLC staff has been in-serviced on documentation regarding resident progress in the medical record by use of the Restorative Weekly Note. Weekly progress towards restorative nursing goals will be documented. The CLC Nurse Manager or designee will conduct monthly audits for documentation of progress using the required Restorative Weekly Note until 90 percent compliance is achieved for 3 months.

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.
- VHA Directive 2009-064, *Recording Observation Patients*, November 30, 2009.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- VHA Directive 6300, *Records Management*, July 10, 2012.
- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[2] References used for this topic included:
- VHA Directive 1105.01, *Management of Radioactive Materials*, October 7, 2009.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.
- VA National Center for Patient Safety, "Privacy Curtains and Privacy Curtain Support Structures (e.g., Track and Track Supports) in Locked Mental Health Units," Patient Safety Alert 07-04, February 16, 2007.
- VA National Center for Patient Safety, "Multi-Dose Pen Injectors," Patient Safety Alert 13-04, January 17, 2013.
- VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, April 11, 2013.
- Deputy Under Secretary for Health for Operations and Management, "Mitigation of Items Identified on the Environment of Care Checklist," November 21, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Change in Frequency of Review Using the Mental Health Environment of Care Checklist," April 14, 2010.
- Deputy Under Secretary for Health for Operations and Management, "Guidance on Locking Patient Rooms on Inpatient Mental Health Units Treating Suicidal Patients," October 29, 2010.
- U.S. Pharmacopeia <797>, *Guidebook to Pharmaceutical Compounding–Sterile Preparations*, June 1, 2008.
- 10 CFR 20, Subpart F.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, the American College of Radiology Practice Guidelines and Technical Standards, Underwriters Laboratories.

[3] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
- Various requirements of The Joint Commission.

[4] References used for this topic included:
- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
- VHA Handbook 1907.01.
- The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, July 2013.

[5] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

[6] References used for this topic included:
- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

[7] References used for this topic included:
- VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008.
- VHA Handbook 1142.03, *Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS)*, January 4, 2013.
- Centers for Medicare and Medicaid Services, *Long-Term Care Facility Resident Assessment Instrument User's Manual*, Version 3.0, May 2013.
- VHA Manual M-2, Part VIII, Chapter 1, *Physical Medicine and Rehabilitation Service*, October 7, 1992.
- Various requirements of The Joint Commission.