Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00075-87

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

January 20, 2016

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
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA St. Louis Health Care System
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of this follow-up review was to assess the status of action plans in response to the recommendations from our prior Combined Assessment Program review and to re-evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of November 2, 2015.

Review Results: The review covered nine activities. For the following seven activities, we made no new recommendations and where applicable, closed recommendations when actions plans were completed:

- Quality Management
- Medication Management
- Coordination of Care
- Magnetic Resonance Imaging Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- Emergency Airway Management

Recommendations: We made new recommendations in the following two activities:

Environment of Care: Ensure access to exits is unrestricted. Require that all nurse call system alarms are functioning. Ensure emergency response medications and equipment are available for immediate use in patient care areas. Require that electrical power strips are not plugged into other power strips. Ensure crash carts using electrical power strips have those strips permanently attached. Require that patient care areas do not contain portable space heaters.

Mental Health Residential Rehabilitation Treatment Program: Repair or replace the uneven and buckling flooring in the combined Domiciliary and Substance Abuse Residential Rehabilitation Treatment Program. Ensure compliance with Safety Data Sheet recommendations regarding chemical storage, use, and safety. Post signage identifying the location of alternative exits during construction projects. Install signage to clearly identify the location of fire extinguishers in large rooms and those obstructed from view.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program follow-up review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 25–31, 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
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Objective and Scope

Objective

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 objective of this CAP follow-up review was to assess the status of action plans in response to the recommendations from our prior CAP review and to re-evaluate selected health care facility operations, focusing on patient care quality and the EOC.

Scope

The scope of this CAP follow-up review was limited. We re-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 nine activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM
- MH RRTP

We have listed the general information reviewed for each of these activities. This follow-up review covered facility operations for January 2015 through November 6, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. Additionally, we asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA St. Louis Health Care System, St. Louis, Missouri,* Report No. 15-00075-351, May 18, 2015).

In this report, we make new recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

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.[a]

We conversed with senior managers and key QM employees, and we evaluated 21 credentialing and privileging folders, meeting minutes, and other relevant documents for the review period January–October 2015. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.	During our previous review, we recommended that the Facility Director continue to chair Quality Executive Board meetings.	The facility completed an action plan, and we considered this recommendation closed.
X	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.	During our previous review, we recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.	The facility completed an action plan, and we considered this recommendation closed.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	During our previous review, we recommended that: • The Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms and document the review. • Licensed independent practitioners who perform EAM have properly approved/signed privilege forms. • Licensed independent practitioners' folders do not contain non-allowed information.	The facility's action plans for these recommendations are still in progress; therefore, we did not close these recommendations.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed 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. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	During our previous review, we recommended that: • The facility implement a policy that defines Surgical Work Group membership. • The Surgical Work Group document its review of National Surgical Office reports and its review of all surgical deaths with identified problems or opportunities for improvement.	The facility completed an action plan, and we considered these recommendations closed.
X	Clinicians appropriately reported critical incidents.	During our previous review, we recommended that clinicians report all critical incidents through the facility's adverse event reporting process.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	During our previous review, we recommended that the facility review the quality of entries in the EHR and analyze data at least quarterly.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	During our previous review, we recommended that the facility fully implement the new quality control policy for scanning.	The facility completed an action plan, and we considered this recommendation closed.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

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. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

At the John Cochran division, we inspected critical care (medical/surgical intensive care unit), the Emergency Department, inpatient units (progressive care, surgical, spinal cord injury, and two medicine), and primary care and surgical specialty care clinics. At the Jefferson Barracks division, we inspected the CLC, the MH inpatient unit, the spinal cord injury unit, the podiatry clinic, and primary care clinics. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 35 employee training records (14 critical care and 21 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	During our previous review, we recommended that EOC Committee minutes include discussion regarding EOC rounds deficiencies.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met fire safety requirements.	During our current review, in four of 12 patient care areas, equipment in corridors restricted access to exits.	**1.** We recommended that facility managers ensure access to exits is unrestricted and monitor compliance.
X	The facility met environmental safety requirements.	During our previous review, we recommended that: • Facility managers ensure patient care areas and public restrooms are clean. • The facility repair damaged furniture in patient care areas or remove it from service. • The facility store oxygen tanks in a manner that distinguishes between empty and full tanks. • Facility managers ensure all electrical gang boxes have the appropriate covers installed. During our current review, 2 of 12 patient care areas had nurse call system alarms that were unplugged/disabled at the nurses' station.	The facility's action plan for these recommendations is still in progress; therefore, we did not close these recommendations. **2.** We recommended that facility managers ensure all nurse call system alarms are functioning and monitor compliance.
X	The facility met infection prevention requirements.	During our previous review, we recommended that the facility: • Store clean and dirty items separately • Promptly remove outdated commercial supplies from sterile supply rooms	The facility's action plan for these recommendations is still in progress; therefore, we did not close these recommendations.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met medication safety and security requirements.	During our previous review, we recommended that the facility promptly remove expired medications from patient care areas. During our current review, the MH inpatient unit did not have emergency medications and equipment available for immediate use.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation. **3.** We recommended that facility managers ensure emergency response medications and equipment are available for immediate use in patient care areas and monitor compliance.
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	During our previous review, we recommended that the facility label medications in accordance with local policy. During our current review: • Three of 12 patient care areas had electrical power strips that were plugged into other power strips, which posed a safety issue. • One of 12 crash carts using an electric power strip did not have the strip permanently attached, which posed a safety issue. • One of 12 patient care areas contained a portable space heater, which posed a safety issue.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation. **4.** We recommended that facility managers ensure electrical power strips are not plugged into other power strips and monitor compliance. **5.** We recommended that facility managers ensure crash carts using electrical power strips have those strips permanently attached. **6.** We recommended that facility managers ensure patient care areas do not contain portable space heaters and monitor compliance.
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
X	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.	During our previous review, we recommended that the facility inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
	The facility met fire safety requirements in critical care.		
X	The facility met environmental safety requirements in critical care.	During our previous review, we recommended that facility managers ensure: • Patient care areas and public restrooms are clean. • All electrical gang boxes have the appropriate covers installed.	The recommendations for these findings appeared under the general environment of care section. The facility's action plans are still in progress; therefore, we did not close the recommendations.
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	During our previous review, we recommended that the facility label medications in accordance with local policy. During our current review: • This area had an electrical power strip that was plugged into another power strip. • This area contained a portable space heater.	The recommendation for this finding appeared under the general environment of care section. The facility's action plan for this recommendation is still in progress; therefore, we did not close the recommendation. See recommendations 4 and 6.

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	During our previous review, we recommended that the facility document functionality checks of the CLC's elopement prevention system at least every 24 hours and conduct and document annual complete system checks.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
X	The facility met fire safety requirements in the CLC.	During our current review, stationary items in corridors restricted access to exits.	See recommendation 1.
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
X	The facility met medical equipment requirements in the CLC.	During our previous review, we recommended that the facility inspect and tag critical medical equipment in the CLC.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
	The facility met privacy requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	During our previous review, we recommended that the facility label medications in accordance with local policy. During our current review, the crash cart on the first floor using an electric power strip did not have that strip permanently attached, which posed a safety issue.	The recommendation for this finding appeared under the general environment of care section. The facility's action plan for this recommendation is still in progress; therefore, we did not close the recommendation. See recommendation 5.
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the CLC, inpatient units (medicine and surgical), and the critical care unit (medical/surgical intensive care) and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
X	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.	During our previous review, we recommended that facility managers ensure crash cart logs contain the correct lock numbers.	The facility completed an action plan, and we consider this recommendation closed.
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.	During our previous review, we recommended that the facility ensure the look-alike and sound-alike medication list is available for staff reference in all areas.	The facility completed an action plan, and we consider this recommendation closed.
X	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.	During our previous review, we recommended that the facility ensure the high-alert medication list is available for staff reference.	The facility completed an action plan, and we consider this recommendation closed.
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had a consult requested during an acute care admission from July 1 through September 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	A committee oversaw the facility's consult management processes.	During our previous review, we recommended that the facility create/designate a committee to oversee consult management.	The facility completed an action plan, and we considered this recommendation closed.
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults	During our previous review, we recommended that: • The Medicine, MH, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package. • Medicine, MH, Surgical, and Rehabilitation Services designate an individual to review and manage consults.	The facility completed an action plan, and we considered these recommendations closed.
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	During our previous review, we recommended that requestors consistently select the proper consult title.	The facility completed an action plan, and we considered this recommendation closed.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) employee safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 54 employees (30 Level 1 ancillary staff and 24 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 patients who had an MRI July 1–September 30, 2015. Additionally, we conducted a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	During our previous review, we recommended that the facility complete secondary patient safety screenings immediately prior to MRI.	The facility completed an action plan, and we considered this recommendation closed.
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	During our previous review, we recommended that radiologists and/or Level 2 MRI personnel document resolution in patients' EHRs of all identified MRI contraindications prior to the scan.	The facility completed an action plan, and we considered this recommendation closed.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	During our previous review, we recommended that the facility ensure: • All designated Level 1 ancillary staff receive annual level-specific MRI safety training. • All designated Level 2 MRI personnel receive annual level-specific MRI safety training.	The facility completed an action plan, and we considered these recommendations closed.
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents and the EHRs of 10 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the CLC, the Emergency Department, the critical care unit (medical/surgical intensive care), and six inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	During our previous review, we recommended that the facility revise the stroke policy to address a stroke team and data gathering for analysis and improvement and that facility managers fully implement the revised policy.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	During our previous review, we recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided printed stroke education to patients upon discharge.		
NA	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	During our previous review, we recommended that the facility collect and report to VHA the percent of patients with stroke symptoms who had the stroke scale completed and the percent of patients screened for difficulty swallowing before oral intake.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of five employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had a recommendation from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	During our previous review, we recommended that Radiology Service revise the computed tomography scan, MRI/magnetic resonance angiograms, and radiology interpretation on-call policy to require a 30-minute reporting time.	The facility completed an action plan, and we considered this recommendation closed.
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of 11 clinicians applicable for the review period August 1–31, 2015, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	During our previous review, we recommended that the facility ensure initial clinician EAM competency assessment include all required elements.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	During our previous review, we recommended that the facility ensure: • Clinician reassessment for continued EAM competency is completed at the time of renewal of privileges or scope of practice. • Clinician reassessment for continued EAM competency include completion of all required elements at the time of renewal of privileges or scope of practice. • Clinicians reassessed for continued EAM competency have a statement related to EAM included in an approved scope of practice.	The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation. The facility's action plan for this recommendation is still in progress; therefore, we did not close this recommendation. The facility completed an action plan, and we considered this recommendation closed.
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	During our previous review, we recommended that the facility ensure a clinician with EAM privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care.	The facility's action plan implementation for this recommendation is still in progress; therefore, we did not close this recommendation.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
X	The facility complied with any additional elements required by VHA or local policy.	During our previous review, we recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.	The facility's action plan implementation for this recommendation is still in progress; therefore, we did not close this recommendation.

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary and Substance Abuse RRTPs complied with selected EOC requirements.[i]

We reviewed relevant documents, inspected the combined Domiciliary and Substance Abuse RRTP and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM either did not meet applicable requirements during this follow-up review and needed improvement or had recommendations from the previous review that had not been closed. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The residential environment was clean and in good repair.	During our current review, the Domiciliary and Substance Abuse RRTP combined locations had uneven and buckling flooring, which posed a safety issue.	**7.** We recommended that the facility repair or replace the uneven and buckling flooring in the combined Domiciliary and Substance Abuse Residential Rehabilitation Treatment Program.
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	During our previous review, we recommended that facility managers ensure that only authorized patients, staff, and visitors access the Domiciliary RRTP.	The facility completed an action plan, and we consider this recommendation closed.
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.	During our previous review, we recommended that facility managers ensure that the Domiciliary RRTP does not have closed circuit television in treatment areas.	The facility completed an action plan, and we consider this recommendation closed.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
X	The facility complied with any additional elements required by VHA or local policy.	During our current review, the Domiciliary and Substance Abuse RRTP combined locations had: • Storage and use of residents' cleaning chemicals that did not comply with Safety Data Sheet recommendations for personal protective equipment and first aid measures • No signage identifying the location of alternative exits for an ongoing construction project • No signage identifying the location of fire extinguishers located in a large room or those obscured from view	**8.** We recommended that facility managers ensure compliance with Safety Data Sheet recommendations regarding chemical storage, use, and safety. **9.** We recommended that facility managers ensure signage identifying the location of alternative exits is posted during construction projects. **10.** We recommended that facility managers ensure signage is installed to clearly identify the location of fire extinguishers in large rooms and those obstructed from view.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 23, 2015

From: Director, VA Heartland Network (10N15)

Subject: **CAP Follow-Up 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 OIG CAP CBOC)

1. I have reviewed the report of the Combined Assessment Program Follow-Up Review of the VA St Louis Health Care System. I concur with the responses and action plans developed by the facility.

2. If you have any questions or require additional information, please contact Mary O'Shea, VISN 15 Quality Management Officer.

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 16, 2015

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

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

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and respond to the Combined Assessment Program Follow-Up Review of the VA St. Louis Health Care System, St. Louis Missouri.

2. I have reviewed and concur with the recommendations. Action plans have been developed and documented in this report.

3. If you have any questions, please contact Kelly Schroeder, Acting Director, Quality Management.

Patricia L. Ten Haaf, RN, PhD, FACHE
Interim Medical Center Director
VA St. Louis Health Care System

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 facility managers ensure access to exits is unrestricted and monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: In December 2015, the Facility Safety Officer developed a database to guide and document audits of exit egress paths. The Facility Safety Office personnel will reinforce education related to egress obstruction to staff and unit level managers during walking audits. Facility Safety Officer will report the audit findings to the Environment of Care Committee (EOCC) monthly, beginning January 2016. EOCC minutes will document discussion of opportunities for improvement. The Acting Director, Quality Management will monitor the percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. Report status will be communicated to Quality Executive Board monthly.

Recommendation 2. We recommended that facility managers ensure all nurse call system alarms are functioning and monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: In November 2015, the Facility Safety Officer communicated the OIG CAP Follow-Up findings, related to nurse call system functionality, to all Nurse Managers. Nurse Managers have included nurse call system functionality checks and veteran call system knowledge checks into daily veteran centered rounds. Safety Office personnel will conduct weekly audits of the nurse call system functionality. The Facility Safety Officer will report the audit findings to the Environment of Care Committee (EOCC) monthly, beginning January 2016. The EOCC minutes will document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 3. We recommended that facility managers ensure emergency response medications and equipment are available for immediate use in patient care areas and monitor compliance.

Concur

Target date for completion: March 1, 2016

Facility response: The Chair of the Emergency Resuscitation Committee will conduct a risk assessment related to location and accessibility of emergency medications and equipment in the acute mental health units. The Chair of the Emergency Resuscitation Committee will document the outcome of the multidisciplinary assessment in the Emergency Resuscitation Committee minutes. The Chair, Emergency Resuscitation Committee will ensure Medical Center Memorandum 11-13 EMERGENCY RESUSCITATION; ATTACHMENT C is appropriately updated to reflect change(s). The Emergency Resuscitation Committee minutes will be communicated up to the Performance Improvement Committee. The Acting Director Quality Management will provide status on this recommendation monthly to Quality Executive Board.

Recommendation 4. We recommended that facility managers ensure electrical power strips are not plugged into other power strips and monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: The Associate Director distributed facility-wide email related to potential safety concerns related to inappropriate and unsafe use of power strips. The Facility Safety Officer will conduct weekly audits to identify any double power strip use. Facility Safety Officer will report the audit findings to the Environment of Care Committee (EOCC) monthly, beginning January 2016. The EOCC minutes will document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 5. We recommended that facility managers ensure crash carts using electrical power strips have those strips permanently attached.

Concur

Target date for completion: July 1, 2016

Facility response: The Chief Facility Engineering Service (FES) developed a timeline to accomplish power strip hard-mount for all crash carts. Chief FES will report findings to the Environment of Care Committee (EOCC) monthly beginning January 2016. The

Chair of the Environment of Care Committee will ensure Chief FES reports deficiencies and opportunities for improvement. The Director, Quality Management will monitor the percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 6. We recommended that facility managers ensure patient care areas do not contain portable space heaters and monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: The Associate Director distributed facility-wide email related to portable space heaters in clinical areas. The Facility Safety Office personnel conducted a physical facility sweep to identify current users of prohibited devices, removed devices as indicated and provided instruction on who to contact for cold environment complaints. The Facility Safety Officer is responsible to ensure weekly unannounced audits are conducted on the presence of portable space heaters. Facility Safety Officer will report audit findings to Environment of Care Committee (EOCC) monthly beginning January 2016. EOCC minutes will document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 7. We recommended that the facility repair or replace the uneven and buckling flooring in the combined Domiciliary and Substance Abuse Residential Rehabilitation Treatment Program.

Concur

Target date for completion: May 1, 2016

Facility response: The Chief, Facility Engineering Service has ensured flooring defects have posted signage and markings in the interim, until permanent repairs can be made. The Domiciliary Residential Rehabilitation Treatment Program (DRRTP) Acting Manager educated all staff and veteran program participants on the current hazard and floor replacement plan. Chief Facility Engineering Service will report flooring replacement implementation status to (EOCC) monthly beginning January 2016. EOCC minutes will document discussion of flooring replacement status. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to April 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 8. We recommended that facility managers ensure compliance with Safety Data Sheet recommendations regarding chemical storage, use, and safety.

Concur

Target date for completion: July 1, 2016

Facility response: The Facility Industrial Hygienist conducted a facility sweep validating chemical inventory and the presence of the correct Safety Data Sheets. The Facility Industrial Hygienist has reinforced education on the process to obtain online Safety Data Sheets. The Industrial Hygienist will conduct monthly audits of chemical inventories and related Safety Data Sheets. The Industrial Hygienist will report to Environment of Care Committee (EOCC) monthly beginning January 2016. EOCC minutes will document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 9. We recommended that facility managers ensure signage identifying the location of alternative exits is posted during construction projects.

Concur

Target date for completion: July 1, 2016

Facility response: The Chief, Facility Engineering Service will ensure Project Managers conduct daily project site assessments, inclusive of required signage. The Facility Safety Officer will conduct weekly unannounced audits of project sites for compliance with alternate exit signage. The Facility Safety Officer will report the audit findings to the Environment of Care Committee (EOCC) monthly beginning January 2016. EOCC minutes will document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Recommendation 10. We recommended that facility managers ensure signage is installed to clearly identify the location of fire extinguishers in large rooms and those obstructed from view.

Concur

Target date for completion: July 1, 2016

Facility response: Facility Safety Officer has conducted a facility sweep to validate all fire extinguisher location(s) and the presence of appropriate signage. The Facility Safety Officer will report to Environment of Care Committee (EOCC) monthly beginning January 2016. EOCC minutes document discussion of deficiencies and opportunities for improvement. The Acting Director, Quality Management will monitor percentage of Environment of Care Committee meeting minutes for the six month period January 2016 to June 2016 (divided by the number of Environment of Care Committee meetings multiplied by 100) with goal of >/=90%. The report status will be communicated to Quality Executive Board monthly.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at **www.va.gov/oig**.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- 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*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non- Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[i] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[i] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Various requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.