Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00400-190

Combined Assessment Program Review of the St. Louis VA Medical Center St. Louis, Missouri

August 26, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

Table of Contents

Executive Summary

Introduction

During the week of May 5–9, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the St. Louis VA Medical Center (the medical center), St. Louis, MO. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 269 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strength and reported accomplishment:

- Diversity Award Recipient.

We made recommendations in five of the activities reviewed. Five recommendations were repeat recommendations from our two most recent CAP reviews. For these activities, the medical center needed to:

- Ensure that performance data is used in the credentialing and privileging (C&P) process, in accordance with Veterans Health Administration (VHA) policy.
- Meet VHA requirements for cardiopulmonary resuscitation (CPR) training for all clinically active staff.
- Ensure that contracted providers are not privileged beyond their association with the medical center.
- Meet VHA timeliness requirements for peer reviews (PRs).
- Meet VHA requirements for inter-rater reliability (IRR) reviews for the utilization management (UM) program.
- Meet VHA requirements for copying and pasting text into the electronic medical record.
- Require that moderate sedation data be critically analyzed, trended, and monitored.
- Complete operative reports in accordance with VHA policy.
- Ensure that processes are in place to address patient flow in temporary bed and overflow locations.
- Correct infection control (IC) vulnerabilities.
- Correct safety vulnerabilities.

- Correct patient privacy vulnerabilities.
- Evaluate inpatient mental health overflow, ensure proper unit designation, and complete environmental planning to assure patient safety.
- Conduct controlled substances (CS) inspections in accordance with VHA policy.
- Correct all identified environment of care (EOC) findings within the pharmacy at the Jefferson Barracks (JB) division.
- Correct the identified privacy concerns at the JB division.
- Comply with VHA employment screening requirements.
- Ensure that CPR training is documented in the electronic training record, as required by medical center policy.
- Ensure that all providers privileged to administer moderate sedation have documentation of current training in airway management and cardiac arrhythmias.
- Ensure that providers who administer moderate sedation obtain privileges in accordance with VHA policy.

The medical center complied with selected standards in the following activity:

- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 21–32, for the full text of the Directors' comments.) We will follow up on all planned actions until they are completed.

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

Introduction

Profile

Organization. The medical center is a two-division facility that provides a broad range of inpatient and outpatient health care services. The John Cochran (JC) division is located in midtown St. Louis, and the JB division is located in south St. Louis County. Outpatient care is also provided at three community based outpatient clinics in St. Charles and St. Louis, MO, and in Bellville, IL. The medical center is part of VISN 15 and serves a veteran population of about 251,000 throughout the city of St. Louis, 7 counties in Missouri, and 14 counties in Illinois.

Programs. The medical center provides inpatient and ambulatory medicine, surgery, psychiatry, neurology, and rehabilitation services in more than 65 subspecialties. It has 143 hospital, 71 nursing home, and 50 domiciliary beds.

Affiliations and Research. The medical center is affiliated with Saint Louis University and Washington University and provides training for 43 residents, as well as other disciplines, including diagnostic radiology, laboratory, nuclear medicine, neurology, and psychiatry. In fiscal year (FY) 2007, the medical center's research program had 14 projects and a budget of $1.3 million. Important areas of research included metabolism in aging, blood brain barrier and alcoholism, role of glutamate pathway in dementia, evaluation of stress response systems in Gulf War veterans, and vocal cord paralysis.

Resources. In FY 2007, medical care expenditures totaled $326.7 million, and the medical care budget was $327.6 million. FY 2007 staffing was 1,806 full-time employee equivalents (FTE), including 172 physician and 508 nursing FTE.

Workload. In FY 2007, the medical center treated 51,570 unique patients and provided 52,661 inpatient days in the hospital, 20,627 inpatient days in the Nursing Home Care Unit (NHCU), and 14,617 inpatient days in the domiciliary. The inpatient care workload totaled 8,326 hospital discharges, 773 NHCU discharges, and 129 domiciliary discharges. The average daily census, including NHCU patients, was 241. Outpatient workload totaled 351,292 visits.

Objectives and Scope

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

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

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

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

- EOC.
- Follow-Up on Background Investigations and Security Clearances.
- Follow-Up on Moderate Sedation Practices.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through May 2, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our two most recent CAP reviews of the medical center (*Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri,* Report No. 06-02818-100, March 14, 2007, and *Combined*

Assessment Program Review of the VA Medical Center, St Louis, Missouri, Report No. 04-01893-148, June 2, 2005).

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Quality of Care Review, Veterans Affairs Medical Center, St. Louis, Missouri,* January 22, 2008. In that report, the OMI made recommendations to improve the care for spinal cord injury/disorder (SCI/D) patients.

We reviewed the medical center's follow-up documentation and plans in response to the OMI recommendations and consider the medical center's actions appropriate. Although construction of the satellite SCI/D unit is pending, we consider the OMI recommendations closed.

During this review, we also presented fraud and integrity awareness briefings for 269 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Diversity Award Recipient

In FY 2006, the medical center received the Under Secretary for Health's Diversity Award in Workforce Development and Succession Planning. The "School at Work" program, designed to enhance employee core competency skills for career mobility, and the "Read at Work" program, designed to enhance employee reading and writing skills, were key components in the Diversity Advisory Board's selection of the medical center for this award. Since FY 2006, additional programs have been developed, including the "College at Work" program (onsite college credit classes for employees after work), the "Facility Leadership Enhancement and Development" program (a mentorship program to enhance employee leadership skills), and the "Industrial Technology" program (onsite engineering skills development through courses for employees). The medical center pays fees for tuition and books for employees who enroll in any of these programs. Additionally, the medical center sponsors the

"High School Partnerships" program, which provides instruction in biomedical engineering, pharmacy, and nursing as potential career choices for students.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director, the Chief of Staff, and key employees. Senior managers were supportive of performance improvement (PI) activities. We reviewed plans, policies, committee minutes, and other relevant documents for FY 2007 and identified six program areas that required further management attention. We identified two program areas from our March 14, 2007, CAP review that will remain open. Additionally, we followed up on delinquent operative reports discovered during a recent OIG inspection at the medical center.

Credentialing and Privileging Process. VHA policy[1] requires that the reprivileging process include an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on clinician-specific PI activities. Our March 14, 2007, CAP review identified that PI data used during the reprivileging process needed to be expanded to include more meaningful areas, such as medication usage and medical record documentation. We were informed that the medical center's new PI policy was recently approved and will include more meaningful data collection. This recommendation will remain open until the process has been implemented and monitored.

VHA policy[2] requires that all clinically active staff have current CPR training. We reviewed 12 randomly selected C&P folders of newly appointed clinicians and clinicians who had been reprivileged in the past 12 months. We found that of the seven newly appointed clinicians, five did not have

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, March 6, 2001.
[2] VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support*, July 31, 2002.

current CPR training. Of the five reprivileged clinicians, two did not have current CPR training.

We were told during our interview with credentialing staff that providers contracted for 1 year were given clinical privileges for a total of 2 years. This was partly due to the fact that the C&P process was performed every 2 years.

Peer Review Process. Once the need for a PR is determined, VHA[3] and medical center policies[4] require that initial reviews be completed within 45 days and that PR Committee evaluations be completed within 120 days. The PR process needed to be improved to ensure timely completion of reviews. Of the 109 PRs performed during FY 2007, 20 exceeded 45 days for completion of the initial review, and 6 exceeded 120 days for final evaluation by the committee.

PR data was trended for outcome levels and level changes; however, PR data was not trended for follow-up action items or for recommendations that resulted from the PRs. This was a recommendation from our prior CAP review and will remain open until completed.

Utilization Management Program. VHA policy[5] defines program components that must be in place to perform UM functions. The medical center did not comply with VHA policy regarding IRR[6] reviews. We were informed during our interview with UM staff that IRR reviews had been conducted in the past; however, they were not being performed at the time of our review.

Medical Record Review. VHA policy[7] requires that a process be in place to monitor the copying and pasting of text into the electronic medical record. The medical center's policy and bylaws also address this issue; however, no monitoring was performed to ensure compliance.

Operative and Invasive Procedures. Moderate sedation outcomes and the use of reversal agents were not monitored consistently during FY 2007. Additionally, moderate

[3] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[4] Medical Center Memorandum 00-65, *Peer Review for Quality Management*, March 24, 2005.
[5] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[6] IRR is the extent to which two or more individuals agree.
[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

sedation data was not critically analyzed to identify opportunities for improvement.

Delinquent Operative Reports. During a recent OIG inspection at the medical center, it was discovered that as of April 20, 2008, 117 operative reports had not been completed in a timely manner. One of the operative reports on this list dated back to 2004. Joint Commission standards and VHA[8] and medical center[9] policies require that an operative report be completed following a procedure. As of May 6, 2008, 53 operative reports remained delinquent.

Patient Flow. There was no documented plan or process for patients receiving care in temporary bed locations. Additionally, there was no documented plan for the delivery of services to non-admitted patients placed in overflow locations within the medical center.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that performance data is used in the C&P process, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Beginning September 5, 2008, the service chief will ensure that PI data used for reprivileging will be available at each level of review and approval. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that all clinically active staff complete CPR training, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Administrative Officer/Business Manager (AO/BM) will obtain copies of CPR cards and forward them to the Credentialing Coordinator for entry into the medical center's privilege database. The Chief of Staff will notify licensed independent practitioners (LIPs) without evidence of CPR training to obtain CPR training.

[8] VHA Handbook 1907.01.
[9] Medical Center Memorandum 11-04, *Medical Staff Bylaws and Rules and Regulations*, December 17, 2006, and Medical Center Memorandum FMS MR-01, *Management of Health Records*, February 12, 2007.

The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that contracted providers are not privileged beyond their association with the medical center.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Human Resources (HR) will revise the medical center's policy to state that privileges will not exceed the length of the contract. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that PRs are timely conducted, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of QM and the Risk Manager created additional fields and reports for the medical center's PR tracking database to identify pending reviews and capture follow-up actions and recommendations. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director meets VHA requirements for IRR reviews for the UM program.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of QM established a procedure to complete IRR reviews for UM/utilization review staff on a quarterly basis. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director meets VHA requirements for copying and pasting text into the electronic medical record.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Health Information Management Service and the Chair of the Medical Records Review Committee will develop a

procedure for monitoring the copying and pasting of text into the electronic medical record. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation data be critically analyzed, trended, and monitored.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of Staff, with approval of the Executive Committee of the Medical Staff, established the Invasive Procedure Committee to standardize the monitoring of the quality of care and outcomes of non-operating room invasive procedures. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that operative reports be completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Chief of Surgery will develop a standard operating procedure to monitor timely completion of operative notes and actions for non-compliance. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that processes are in place to address patient flow in temporary bed and overflow locations.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Associate Director for Patient and Nursing Service will establish a workgroup to develop a plan for the delivery of services to non-admitted patients in overflow locations. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center had established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, maintained an effective IC

program, and identified hazards that might pose a safety threat to patients and staff on locked mental health units.

At the JC division, we inspected the medical and surgical units, the Yellow Clinic (ambulatory care), the emergency room, and the Veterans Canteen Service dining area. At the JB division, we inspected the locked acute psychiatric units and the locked geriatric psychiatric unit. We also followed up on recommendations from our March 14, 2007, CAP review. Refrigerator temperature monitoring was again problematic.

Managers were responsive to identified environmental concerns. The IC program monitored, trended, and analyzed data and reported results to clinicians for quality improvements. The Multidisciplinary Safety Inspection Team conducted risk assessments of the three locked acute psychiatric units and the one locked geriatric psychiatric unit. Staff were pursuing corrective actions for the identified vulnerabilities. The following deficiencies required further management attention.

Infection Control. Emergency call system cords must be accessible and easily cleaned as they are often located in shower areas and near commodes and sinks. The medical center was in the process of changing rope-style cords to plastic cords; however, we noted that several cords were not accessible from the floor. Additionally, we noted that tape was used as a pull cord for an overbed light.

Medication and nourishment refrigerator temperatures must be monitored daily to ensure that the contents are safe. When a refrigerator is found to be out of the acceptable temperature range, an employee needs to initiate corrective action (such as adjusting the temperature control or creating a work order for repair). The action should be documented in the refrigerator log so that other employees are aware of what was done. We noted that staff did not consistently document actions taken when refrigerator temperatures were out of range. This was a repeat finding from the March 14, 2007, CAP review. We also noted some refrigerators were frequently problematic and needed to be replaced.

Medications were stored in an automated dispensing machine in a secured room on the locked geriatric psychiatric unit at the JB division. Upon entering the area, we noted that the temperature in the room was significantly

warmer than the hallway temperature. We recommended that immediate action be taken to determine the cause and to ensure that medications were not compromised.

Patient care equipment and furniture needs to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We identified two wheelchairs with tattered armrests and several damaged pads on chairs in an equipment storage room.

Storage areas need to be maintained so that clean and dirty items are separated. We identified several storage rooms that contained a mixture of items, such as clean linens stored with dirty patient care equipment.

Safety. We observed that individual ceiling panels were used in the hallways and dayroom areas of the locked psychiatric units. These panels could potentially be removed. The shower control fixture in the women's shower area on one of the locked psychiatric units needed to be replaced as it could be used as an anchor point for a noose. Additionally, the nurses' station door on this unit was open, potentially allowing unauthorized entry to the area.

Needles and a hemostat were found in unlocked carts and totes in the hallway of a medical unit. These items needed to be secured.

Medications and cleaning products must be secured at all times. Lidocane[10] was left on a bedside stand in a patient room. Saline[11] was found in an unlocked cart in a hallway. Sodium chloride[12] was found near a sink in a patient restroom. A bottle of isopropyl alcohol[13] and a cleaning product were left on top of a shredding receptacle near the nurses' station on a medical unit. We also noted that this medical unit's medication room door lock was inoperable, allowing unrestricted access to the room.

System panel boxes and shut-off valves must be easily accessible to staff for emergency access and repair. We noted that many of these panel boxes and shut-off valves were located in storage rooms on patient care units. Items in

[10] This medication is used as a local anesthetic.
[11] This is a sterile solution of sodium chloride in water that is commonly used for intravenous infusion and irrigation.
[12] This is an agent used in intravenous solutions as a source of electrolytes, hydration, and irrigation.
[13] This product is also commonly known as rubbing alcohol and is used for sterilization.

the storage rooms were placed in a manner that obstructed access. We also noted that many storage rooms had items placed directly on the floor, which is a Life Safety Code issue.

Oxygen tanks must be secured and stored so that staff may quickly recognize if the tanks are full or empty. An oxygen tank located in a secured room on one of the locked psychiatric units was not clearly identifiable as full or empty.

Emergency crash cart inspections for each cart are required to be documented in a log. Documentation includes the number on the plastic locking tag that secures medications in the cart. Upon inspection of the logs, we noted that staff incorrectly transcribed the number of one of the plastic locking tags, and in a second crash cart log, the documented tag number was illegible. We also identified that crash cart checks were not being done as frequently as directed by medical center policy.[14]

On the locked geriatric psychiatric unit, there were shower/restroom areas shared by adjoining patient rooms. Showers operated by push button, and they remained on for a timed interval. We observed that water did not properly drain and flowed out of the room onto the floors in the patient rooms. Nursing staff reported that all shared showers have this problem. The pooling water created an unsafe condition that could result in a fall.

Patient Privacy. Federal law[15] requires that sensitive patient information be secured from unauthorized access. Clipboards with full patient names and social security numbers were hanging from handrails outside patient rooms, left on the tops of carts in hallways, and hanging from patient beds. Patient information was also observed on top of an unattended medication cart in a hallway. A white marker board with patient names, located in a nurses' station on a patient unit, could be viewed from the hallway. Additionally, patient information was found in holding devices located outside examination rooms in the ambulatory care area.

Psychiatric Unit Designation. The locked geriatric psychiatric unit at the JB division also serves as an overflow location for acute psychiatric patients when the three locked acute

[14] Medical Center Memorandum 11-13, *Emergency Resuscitation (Code K)*, August 31, 2004.
[15] Health Insurance Portability and Accountability Act of 1996.

psychiatric units are full. This unit can accommodate 16 patients, and on the day of our inspection, there were 7 acute and 3 geriatric patients. Nursing staff reported that this unit may have 7 to 16 acute patients daily. If this unit treats acute patients, additional environmental considerations are warranted. For example, many of the beds on the unit are hospital beds with handrails that could serve as anchor points and are not appropriate for acute patients who may intend to harm themselves.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that identified IC vulnerabilities be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. Engineering staff will install appropriate cords and heating, ventilation, and air conditioning tie-ins and have developed a contract to install a monitoring system for refrigerators and freezers in the medical center. Patient care equipment will be inspected during EOC rounds. Nursing staff will inspect all storage areas. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that safety vulnerabilities be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. Engineering staff will replace ceiling tiles and grids, the shower control fixture, and the nursing station door. Nursing staff will inspect all storage areas. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that identified patient privacy vulnerabilities be corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nursing staff will eliminate the clipboards with patient information at the patients' bedsides. Patient information will no longer be placed in holding devices. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires an evaluation of inpatient mental health overflow, proper unit designation, and environmental planning to assure patient safety.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Associate Chief of Staff will evaluate the overflow location within mental health. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Operations

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments. We also determined whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA handbooks[16] governing pharmacy and CS security, and we assessed whether the medical center's policies and practices were consistent with VHA regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed Pharmacy Service and Police and Security Service personnel. Additionally, we interviewed staff to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. Our review determined that the medical center had appropriate policies and procedures to ensure the security of the pharmacies and CS. Training records showed that the CS Coordinator and inspectors received appropriate training to execute their duties. However, during our inspection, we found that CS inspectors did not verify 10 percent of all hard copy prescriptions for Schedule II[17] drugs, as required by VHA policy. We were told during our interview with the CS Coordinator that inspectors now verify 50 hard copy prescriptions monthly, which equals or exceeds 10 percent.

[16] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

[17] This category of drugs has a strong potential for abuse or addiction but has legitimate medical uses. Some examples are opium, morphine, and cocaine.

The medical center has 27 CS locations. During the past 6 months, 8 of 164 inspections were not completed in accordance with VHA policy.

Internal Environment of Care. Internal pharmacy EOC was clean and well maintained at the JC division. However, there were areas at the JB division that required further management attention. We found soiled ceiling tiles with numerous unsealed penetrations throughout the pharmacy. The floors were heavily stained and appeared dirty. Several ceiling vents were covered with heavy dust, dirt, and what appeared to be mold. One large vent, mounted on the ceiling in the center of the area, was apparently broken and not in use. The door to this unit was open and covered with excessive dirt and dust. These areas posed IC concerns.

Auditory and Visual Privacy. The outpatient waiting room area at the JB division is small. The room has seating for patients awaiting pharmacy pickup, and there are two clinical pharmacists stationed in this same area performing counseling. There is no privacy for patients being counseled, which is in violation of Federal law.[18]

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to

[18] Health Insurance Portability and Accountability Act of 1996.

treat adverse drug reactions.[19] Some literature suggests elderly and mental health patients are among the most vulnerable populations for polypharmacy.[20]

Managers informed us during our interview that the medical center has a process in place for monitoring polypharmacy. The medical center operates an outpatient medication management clinic. Also, pharmacists document any polypharmacy concerns and suggestions for primary care providers in the patients' medical records.

Recommendation 14 We recommended that the VISN Director ensure that the Medical Center Director requires that CS inspections are completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The CS Coordinator modified the CS inspection tracking sheet to include the date each inspector plans to complete his or her inspections each month. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 15 We recommended that the VISN Director ensure that the Medical Center Director corrects all identified EOC findings within the pharmacy at the JB division.

The VISN and Medical Center Directors concurred with the findings and recommendation. Engineering staff replaced soiled ceiling tiles and sealed ceiling penetrations in the pharmacy. Engineering staff will develop a project to replace the flooring. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 16 We recommended that the VISN Director ensure that the Medical Center Director corrects the identified privacy concerns at the JB division.

The VISN and Medical Center Directors concurred with the finding and recommendation. The pharmacy manager removed some of the seating units to increase the distance between patients waiting for the pharmacist and those being counseled by the pharmacist. The improvement plan is

[19] Yvette C. Terrie, BSPharm, RPh; "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[20] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

acceptable, and we will follow up on the completion of the planned actions.

Follow-Up on Background Investigations and Security Clearances

The purpose of the review was to follow up on background investigation and security clearance findings from the June 2, 2005, CAP review. During that review, we found that a Nuclear Medicine employee with programmer privileges, the Chief of Staff, and the Chief of Police did not have security clearances congruent with their high-risk positions.

On August 14, 2006, the Deputy Under Secretary for Health for Operations and Management sent a memorandum to all Network Directors to clarify screening requirements and establish the process by which documentation of the screening of backgrounds of VHA appointees, contractors, and volunteers will be accomplished. VHA requires the use of a screening checklist for appointments to positions on a full-time, part-time, and intermittent basis. This includes all on-station fee basis positions, consultants, attendings, without compensation positions, residents, and students.

We reviewed Official Personnel Folders and HR Management Service records for 31 physicians who were credentialed and privileged to practice at the medical center. Our sample included fee basis and without compensation providers. There were issues with six physicians' records. Staff were unable to provide background investigation verifications for three of the physicians—two fee basis and one without compensation. Additionally, there was no documentation of background investigations or security clearances for three physicians from our sample who had worked for the medical center for 20 years or more and were reprivileged during the last 12 months.

Recommendation 17 We recommended that the VISN Director ensure that the Medical Center Director complies with VHA employment screening requirements.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of HR will revise the "Standard Operating Procedure on Background Investigation" to include the appropriate filing of documents when an employee moves from a staff position to a without compensation or fee basis position. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Follow-Up on Moderate Sedation Practices

The purpose of this review was to follow up on moderate sedation findings from the March 14, 2007, CAP review. During that review, we found that managers needed to update medical center policy to ensure that all clinical providers have CPR training and monitor compliance.

We reviewed the training records of 22 providers currently privileged to administer moderate sedation. Seven providers did not have evidence of current CPR training. VHA[21] and medical center[22] policies require that all clinical staff have CPR training. Moreover, medical center policy requires that this training be documented in the electronic training record. We found that of the 15 employees who had current training, only 5 had entries in their electronic training records.

Additionally, VHA[23] and medical center[24] policies require training in airway management and cardiac arrhythmias for those who administer moderate sedation. We found that 14 of the 22 providers did not have documentation of this training. This is a repeat finding from the June 2, 2005, and the March 14, 2007, CAP reviews. Recommendation 2 on page 7 of this report addresses the CPR training portion of this finding.

Further, we requested the approved reprivileging applications for the 22 providers reviewed. We found that three providers had not requested privileges for moderate sedation administration; therefore, they had not been approved by the medical center's Director, as required by VHA policy.

Recommendation 18 We recommended that the VISN Director ensure that the Medical Center Director requires that CPR training be documented in the electronic training record, in accordance with medical center policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. CPR training for LIPs will be entered and tracked in the medical center's privilege database. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

[21] VHA Directive 2002-046.
[22] Medical Center Memorandum 11-46, *Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support*, December 20, 2006.
[23] VHA Directive 2006-023, *Moderate Sedation By Non-Anesthesia Providers,* May 1, 2006.
[24] Chief of Staff Standard Operating Procedure No. 11-087, *Sedation By Non Anesthesia Providers,* April 30, 2008.

Recommendation 19 We recommended that the VISN Director ensure that the Medical Center Director requires that all providers privileged to administer moderate sedation have documentation of current training in airway management and cardiac arrhythmias.

The VISN and Medical Center Directors concurred with the finding and recommendation. The AO/BM will review each provider's file for evidence of training in airway management and cardiac arrhythmias. Providers without evidence of training will be requested to provide evidence of training within 30 days. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 20 We recommended that the VISN Director ensure that the Medical Center Director requires that providers who administer moderate sedation obtain privileges in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Credentialing Coordinator and the Chief of QM will review the list of all providers with invasive procedure privileges to identify those who did not request sedation privileges. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Review Activities Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VA medical facilities use the quarterly or semi-annual SHEP results to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure (PM) target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 below and Figure 2 on the next page show the SHEP PM results for inpatients and outpatients, respectively.

Figure 1: **ST. LOUIS VA MEDICAL CENTER INPATIENT OVERALL QUALITY BY QUARTER**

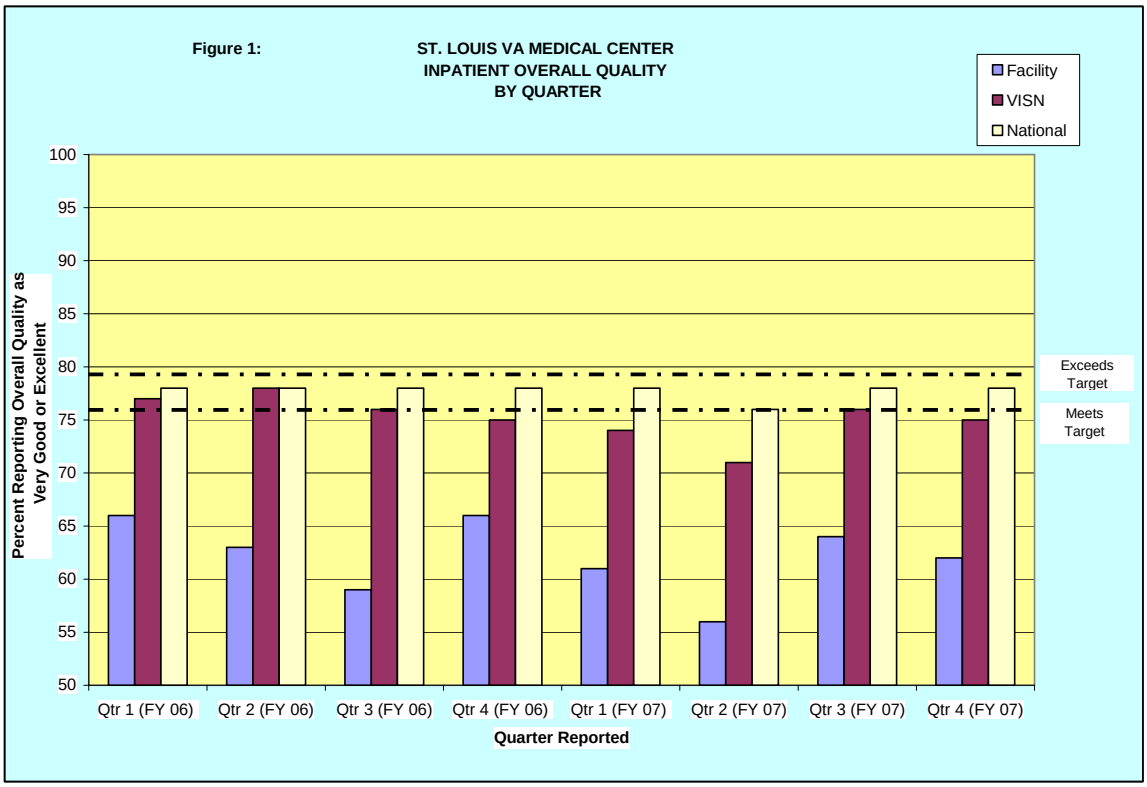
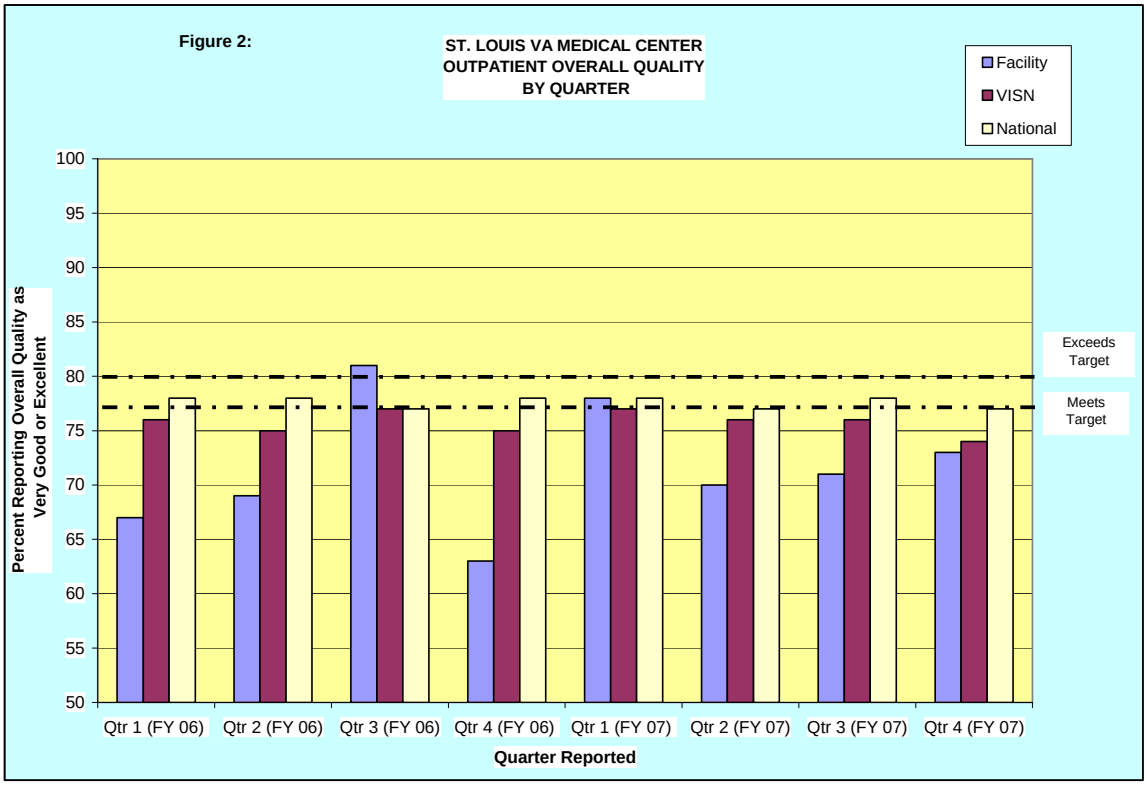


Figure 2: **ST. LOUIS VA MEDICAL CENTER OUTPATIENT OVERALL QUALITY BY QUARTER**



The medical center has not met or exceeded the 76 percent threshold in the last 8 quarters of available data for inpatient overall quality. The medical center scored above the 77 percent threshold in 2 of the last 8 quarters of available data for outpatient overall quality. Managers had identified opportunities for improvement based on the SHEP scores and had developed an action plan targeting specific areas. The action plan was implemented, and there is evidence of ongoing activities, including evaluation of the plan for effectiveness. Additionally, the medical center presented local data indicating improved scores; therefore, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 14, 2008

From: Director, VA Heartland Network VISN 15 (10N15)

Subject: **Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (10B5)

I have reviewed the report from the Inspector General's Combined Assessment Program (CAP) of the St. Louis VA Medical Center. We concur with all the findings and action plans to the recommendations outlined in the report.

PETER L. ALMENOFF, MD, FCCP

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 8, 2008

From: Director, St. Louis VA Medical Center (657/00)

Subject: **Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, Missouri**

To: Director, VISN 15 (10N15)

Attached is the St. Louis VA Medical Center response and actions plan to the OIG report from the Combined Assessment Program that was conducted on May 5–9, 2008.

(*original signed by:*)

GLEN E. STRUCHTEMEYER

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that performance data is used in the C&P process, in accordance with VHA policy.

Concur **Target Date: September 30, 2008**

The medical center revised the Medical and Dental Staff Performance Improvement Plan with approval by the ECMS on May 2, 2008. This revision includes clinician-specific PI data for use in the reprivileging process in a standardized reporting format. The PI Committee has the responsibility for providing oversight and monitoring the implementation of the plan. The Chief of QM will ensure the new standardized report will be populated for each provider and distributed to the provider and the service chief by September 5, 2008. The service chief will document the PI data utilized for the reprivileging process in the service chief approval section of VetPro (VHA's electronic credentialing system) beginning August 1, 2008. The service chief will ensure the PI data used for reprivileging will be available at each level of review and approval beginning September 5, 2008.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinically active staff complete CPR training, in accordance with VHA policy.

Concur **Target Date: August 30, 2008**

The Chief of QM will review and revise the Medical Center Memorandum (MCM) 11-46 "Staff Training in Cardiopulmonary Resuscitation and Advance Cardiac Life Support" to clarify the requirements for LIP by July 30, 2008. This includes: initial appointments must have evidence of completion of CPR, renewal appointments will not be processed without evidence of CPR training; and evidence of training will be tracked in the medical center's privilege database. Chief of Staff will communicate this clarification to the medical and dental staff by August 1, 2008. AO/BM will review a list of all LIPs for status of CPR training by August 1, 2008. The AO/BM will obtain a copy of the CPR card and forward it to the Credentialing Coordinator for entry in the medical center's privilege database by August 15, 2008. The Chief of Staff will notify LIPs without

evidence of CPR training and resources to obtain CPR training. The consequences of not meeting the CPR training requirement will result in suspension of privileges. The Associate Chief of Staff for Education will develop a plan to ensure LIPs have routine access to CPR training at the medical center or through other training sites by July 23, 2008. The Credentialing Coordinator will generate a monthly report of LIPs with CPR expiration dates within the next 90 days and distribute it to the service chiefs' AO/BM for action beginning August 30, 2008. The Credentialing Coordinator will revise the credentialing packet letter by including the CPR training requirement. The Chief of Staff will report each month to the medical center Director the status of LIP's CPR training compliance and action plan to address patient care needs impacted by provider non-compliance beginning July 30, 2008.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that contracted providers are not privileged beyond their association with the medical center.

Concur **Target Date: August 8, 2008**

The Chief of HR completed a review of all privileged contracted staff to determine those who had been granted privileges past the contract end date on June 30, 2008. The Chief of HR will revise the procedure for processing contracted provider privileges to coincide with the contract (January 1 to December 31) by July 30, 2008. Contracted providers who have privileges beyond the expiration of the contract will be notified of the change in the privilege expiration date. By August 8, 2008, the Credentialing Coordinator will inform the affected providers via letter of the expiration of their privileges on December 31, 2008. The Chief of HR will revise MCM 11-07 "Credentialing and Privileging" to state that privileges will not exceed the length of the contract by August 8, 2008.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that PRs are timely conducted, in accordance with VHA policy.

Concur **Target Date: September 30, 2008**

During the 4th quarter of FY 2007 the Chief of QM and the RM completed an in-depth analysis of PRs completed during the 1st through 3rd quarter of FY 2007 to identify reasons for cases that were greater than 45 days initial and greater than 120 days overall processing time. It was identified when the initial reviews are completed within 30 days or less all the timeframes are met. The Chief of QM and the RM implemented the following actions to improve the timeliness of PRs: 1) Revision of review request letter to ask for completion of initial review within 14 days of date of letter. 2) Addition of fields and reports in the PR Tracking database to identify the

number of pending in initial review, number assigned to each reviewer, 14 day and 21 day reminder report. 3) Revised reminder procedure by the RM to reviewers. 4) Identified and trained additional cadre of reviewers. These actions were completed October 1, 2007. The RM monitors the timeliness of the PR process and reports to the PR Committee and ECMS at least quarterly. Since implementation, improvement has been seen. The number of initial reviews completed within 45 days through the 3rd quarter of FY 2008 is 103 of 107. The four initial reviews greater than 45 days occurred early in the 1st quarter. The number of final reviews by the committee within 120 days is 107 of 107. None has exceeded 120 days.

The Chief of QM and the RM identified and created additional fields for the medical center's PR tracking database to capture follow-up actions and recommendations on June 17, 2008. The 3rd quarter FY 2008 PR report to ECMS will include trended data for follow-up actions and recommendations.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director meets VHA requirements for IRR reviews for the UM program.

Concur **Target Date: July 15, 2008**

The Chief of QM established a procedure to complete IRR reviews for each utilization management/utilization review staff on a quarterly basis beginning June 17, 2008. It will include a review of at least 10 admissions and 10 continued stay reviews using InterQual Criteria (screening guidelines with respect to medical appropriateness of healthcare services). Results of the IRR review will be shared with the individual reviewed and opportunities for improvement will be addressed. The Chief of QM will provide a report of the summary of the IRR reviews each quarter beginning July 15, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director meets VHA requirements for copying and pasting text into the electronic medical record.

Concur **Target Date: September 30, 2008**

The Chief of HIMS and the Chair of MRRC will develop a procedure for monitoring, copying, and pasting text into the electronic medical record by August 1, 2008. Monitoring according to this procedure will begin August 1, 2008. The Chief of HIMS and the Chair of MRRC will report the results and analysis of copy and paste monitor to the MRRC beginning September 2008. As opportunities for improvement are identified,

appropriate actions will be taken and tracked by the MRRC beginning September 2008.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that moderate sedation data be critically analyzed, trended, and monitored.

Concur **Target Date: September 30, 2008**

During the 4th quarter of FY 2007, the Chief of Staff and Chief of QM completed a review of the medical center's procedures to monitor sedation practices. A fragmented process of each service's monitoring and taking action was identified. This fragmented process led to the lack of trended sedation outcomes and use of reversals in FY 2007. The Chief of Staff with approval of the ECMS established the IPC to standardize the monitoring of quality care and outcomes of non-OR invasive procedures (MCM 00-12.67 "Invasive Procedure Committee"). The IPC defined the sedation outcome measures for routine collection, analysis and identification of opportunities for improvement. These measures were collected, trended, and analyzed to identify opportunities for improvement by service and aggregated on a medical center level beginning October 1, 2007. Data has been consistently collected, trended, and analyzed to identify opportunities for improvement in FY 2008.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that operative reports be completed in accordance with VHA policy.

Concur **Target Date: July 30, 2008**

On April 21, 2008, the Chief of Staff met with the Chief of Surgery and surgery attending staff to educate and reinforce the requirements of timely completion of operative reports within 8 hours of the completion of the surgery. Providers with delinquent operative reports were informed that OR time would be suspended until delinquent operative notes were completed. Beginning April 21, 2008, a daily report of delinquent operative reports was generated by the Surgery Service Administrative Officer or designee. Providers were given a list of delinquent operative report to complete during designated administrative time. The Chief of Surgery will develop a standard operating procedure to monitor timely completion of operative notes and actions for non-compliance by July 30, 2008.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that processes are in place to address patient flow in temporary bed and overflow locations.

Concur **Target Date: September 15, 2008**

On June 30, 2008, the ADPNS, in conjunction with the Chief of Staff, completed a review of patient care areas to identify temporary bed locations where patients would overflow. The ADPNS will establish a workgroup to develop a plan for the delivery of services to non-admitted patients in overflow locations by August 30, 2008. This workgroup will include representatives from logistics, pharmacy, laboratory, radiology, food & nutrition, housekeeping, nursing, informatics, quality management, utilization management and medical staff. Education will be provided to staff and supervisors of the identified temporary bed locations and the services identified in the plan by September 15, 2008.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that identified IC vulnerabilities be corrected.

Concur **Target Date: November 30, 2008**

Engineering staff canvassed all patient bathrooms to identify locations where rope-style cords and to check the length of cords to ensure they are accessible from the floor. All rope-style or short cords were replaced by May 19, 2008.

Engineering staff will canvass all patient rooms to identify overbed lights with tape used as a pull cord and will replace with the appropriate pull cord by July 30, 2008.

Engineering staff has developed a contract to install a centrally monitored system to observe all patient care refrigerators and freezers in the medical center on June 30, 2008. Full implementation of the system will be completed by October 31, 2008. The Environment of Care Committee (EOCC) will provide oversight and monitor this project. As a component of the project, engineering staff will evaluate patient care refrigerators to identify for replacement those refrigerators having frequent problems. Education to reinforce the current patient care refrigerator monitoring policy was completed with supervisors and managers on May 16, 2008.

Engineering staff installed HVAC drop into the medication room on the geriatric psychiatric unit at JB division on May 30, 2008. Engineering staff will complete a HVAC study of all medication and supply areas to identify areas not tied into the HVAC system by September 1, 2008. Engineering staff will install HVAC tie-in for the identified areas by November 30, 2008.

The EOCC established a procedure to periodically inspect patient care equipment and furniture for compromised surfaces as a component of EOC rounds on June 30, 2008. Damaged equipment or furniture will be repaired or replaced as identified. The EOCC will re-educate patient care

staff to report and remove from patient use any damaged equipment and furniture by August 1, 2008.

Nurse managers (NM) and ACN will inspect all storage areas to identify locations where clean and dirty items may be stored together. Each identified location will be designated as clean or dirty with appropriate removal of items, signage and education to the area's staff by August 30, 2008.

The EOC rounds checklist will be modified to include checking bathroom pull cords, overbed light pull cords, room temperature of medication and supply rooms, inspection of patient care equipment and furniture for compromised surfaces, and appropriate storage of clean and dirty patient care items for 6 months beginning July 2008.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that safety vulnerabilities be corrected.

Concur **Target Date: December 31, 2008**

Engineering staff will replace ceiling tiles and grids in the day rooms of locked psychiatric units with a solid ceiling by October 30, 2008. Ceiling panels in main hallways of locked psychiatric units will have plastic tabs installed to prevent access by October 30, 2008. Day room ceiling and hallway ceiling tiles have been placed on MH EOC checklist action plan on May 21, 2008.

Engineering staff will replace the shower control fixture in the women's shower area on one of the locked psychiatric units with an institutional fixture by October 30, 2008. Shower control fixture has been placed on the MH EOC checklist on May 21, 2008. Until fixtures are replaced, the current practice of female nursing staff accompanying female patients while in the women's shower area will continue.

Engineering staff will replace the nursing station door on a locked psychiatric unit with a Dutch door to reduce the risk of allowing unauthorized entry to the area by October 30, 2008. The nurse's station door has been placed on the MH EOC checklist on May 21, 2008.

The EOC rounds checklist will be modified to include unsecured sharps, unsecured medication, unsecured cleaning products, obstructed valves and panels, oxygen storage, and legibility and accuracy of crash cart lock number on checklist for 6 months beginning July 2008.

NMs and ACNs for each patient care area will eliminate the storage of needles and hemostats in unlocked carts. Medication and supply rooms will be reconfigured to all for appropriate storage and access to needles

and hemostats. The ADPNS and ACNs will implement a daily check for unsecured sharps beginning July 1, 2008.

The ACNs, NMs, and supervisors from Environmental Management Service (EMS) will re-educate nursing and EMS staff on the appropriate storage of cleaning products by July 30, 2008. The ACNs and NMs will re-educate staff and reinforce the procedures for the storage and security of medications by July 30, 2008. Engineering staff repaired the lock on the medical unit at JC division on May 9, 2008.

NMs and ACNs inspected all storage areas where access to valves and panels were obstructed and items stored on the floor on July 1, 2008. Items were relocated and storage removed from the floor and placed on risers. Signage will be placed to remind staff not to obstruct access by July 30, 2008.

The Chief of Logistics and the Safety Officer will revise the procedure for oxygen storage to improve the identification of tanks as full or empty by July 30, 2008. The Chief of Logistics and the Safety Officer will educate staff on the revised procedure by August 30, 2008.

The Chief of QM will revise the MCM 11-13 "Emergency Resuscitation (Code K)" to reflect a change in the crash cart checklist and frequency from each shift to daily to align with medical center wide deployment of new defibrillators/Automated External Defibrillators by July 30, 2008. A reminder will be provided to patient care staff on the importance of accurate and legible transcription of lock numbers by July 30, 2008.

Engineering staff will turn off the water to showers in all the combined shower rooms on the locked geriatric psychiatric unit by July 15, 2008. Engineering staff will seek a solution to the floor drain's inability to handle the volume of water. The issue was identified when the unit was reopened after renovation. Since the safety risk was identified, the nursing staff have not been using these showers for patient care. The unit's shower room is being utilized for patients.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that identified patient privacy vulnerabilities be corrected.

Concur **Target Date: July 30, 2008**

The ACOS and ACN for Primary Care reviewed each clinic site for patient privacy vulnerabilities on June 30, 2008. Patient sensitive information has been removed from routing sheets. Routing sheets are handed to the provider. Mailboxes in staff only areas have been placed for each provider to receive telephone messages from patients, which were previously placed in a holding device on provider's door.

ADPNS and ACNs will eliminate the clipboards with patient information at the patients' bedside by July 30, 2008. The patient flow sheets will be stored at the nurse's station.

NMs and ACNs will remind and re-educate staff on appropriate handling of patient sensitive information by July 30, 2008.

Engineering staff relocated the white marker board in the nurse's station so that it is not viewable from the hallway on May 15, 2008.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director requires an evaluation of inpatient mental health overflow, proper unit designation, and environmental planning to assure patient safety.

Concur **Target Date: July 30, 2008**

The ACOS and ACN will evaluate the overflow location within MH for the appropriate designation, environment, and staff competencies to assure patient safety by July 30, 2008.

Recommendation 14. We recommended that the VISN Director ensure that the Medical Center Director requires that CS inspections are completed in accordance with VHA policy.

Concur **Target Date: December 31, 2008**

The CS Coordinator modified the CS Inspection tracking sheet to include the date each inspector plans to complete his/her inspections each month on May 16, 2008. The CS Coordinator modified the oversight procedure with the inspector to validate completion of all monthly inspections. This was implemented May 16, 2008.

Recommendation 15. We recommended that the VISN Director ensure that the Medical Center Director corrects all identified EOC findings within the pharmacy at the JB division.

Concur **Target Date: December 31, 2008**

Engineering staff replaced the soiled ceiling tiles and sealed ceiling penetrations in the pharmacy at the JB division on June 6, 2008. All ceiling vents and the identified unit were cleaned and repaired on June 6, 2008. Engineering staff will develop a project to replace the flooring by December 31, 2008.

Recommendation 16. We recommended that the VISN Director ensure that the Medical Center Director corrects the identified privacy concerns at the JB division.

Concur **Target Date: December 31, 2008**

To address the privacy concerns at the JB division pharmacy, the pharmacy manager removed a portion of the seating units to increase the distance between the patients waiting for the pharmacist and those being counseled by the pharmacist on June 1, 2008. The medical center's Privacy Officer will complete a review of the area and make recommendation for additional actions to address privacy concerns by July 30, 2008. Engineering staff will evaluate the space for reconfiguration by December 31, 2008.

Recommendation 17. We recommended that the VISN Director ensure that the Medical Center Director complies with VHA employment screening requirements.

Concur **Target Date: September 15, 2008**

The Chief of HR will initiate and complete background investigations on the physicians identified by the inspector by August 15, 2008. The Chief of HR will review and revise the HR "Standard Operating Procedure on Background Investigation" to include the appropriate filing of documents when an employee moves from a staff position to a without compensation or fee basis position by August 30, 2008. HR staff will be educated on the revised procedure by September 15. 2008.

Recommendation 18. We recommended that the VISN Director ensure that the Medical Center Director requires that CPR training be documented in the electronic training record, in accordance with medical center policy.

Concur **Target Date: July 30, 2008**

The Chief of HR, Credentialing Coordinator, and Chief of QM reviewed and revised the process for documentation of CPR training for LIPs. CPR training for LIPs will be entered and tracked in the medical center's privilege database. The Chief of QM will revise MCM 11-46 "Staff Training in Cardiopulmonary Resuscitation and Advance Cardiac Life Support" to reflect the change in the documentation process for CPR training for LIPs by July 30, 2008. Please see Recommendation 2 for related actions.

Recommendation 19. We recommended that the VISN Director ensure that the Medical Center Director requires that all providers privileged to administer moderate sedation have documentation of current training in airway management and cardiac arrhythmias.

Concur **Target Date: July 30, 2008**

The service chiefs and QM completed a review of medical center privileges forms during the 2nd quarter of FY 2008. The sedation privilege description was revised to clarify the training required for the privilege. The medical center Director approved the revised privilege forms on March 2, 2008. The Credentialing Coordinator generated a list of providers with sedation privileges on May 30, 2008. The AO/BM will review each provider's file for evidence of training in airway management and cardiac arrhythmias by July 30, 2008. Providers without evidence of training in airway management and cardiac arrhythmias will be requested via letter to provide evidence of training within 30 days. The Chief of Staff will be notified of providers who fail to comply. Action will be taken to suspend privileges for sedation and invasive procedures until evidence of training is provided. The Chief of QM will educate service chiefs on documentation requirements for granting privileges by July 30, 2008. Initial privileges and reappointment privileges will not be recommended by the Professional Standards Board unless evidence of training is present and in the credentialing packet beginning July 15, 2008.

Recommendation 20. We recommended that the VISN Director ensure that the Medical Center Director requires that providers who administer moderate sedation obtain privileges in accordance with VHA policy.

Concur **Target Date: July 30, 2008**

The Credentialing Coordinator and Chief of QM will review the list of all providers with invasive procedure privileges to identify those who did not request the sedation privilege. The providers will be notified via letter and asked to request the sedation privileges by July 30, 2008. Those providers choosing not to request the sedation privilege will be reviewed by the service chief to ensure that the provider does not utilize sedation in practice.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	Verena Briley-Hudson, MN, RN, Director Chicago Office of Healthcare Inspections (708) 202-2672
Contributors	Wachita Haywood, MS, RN, Associate Director Jennifer Reed, RN, Health Systems Specialist, Team Leader Lisa Barnes, MSW, Health Systems Specialist Paula Chapman, CTRS, Health Systems Specialist Roberta Thompson, MSW, Health Systems Specialist James Werner, Special Agent, Office of Investigations Judy Brown, Program Support Assistant

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 15 (10N15)
Director, St. Louis VA Medical Center (657/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Christopher S. Bond, Richard Durbin, Claire McCaskill, Barack Obama
U.S. House of Representatives: Todd Akin, Russ Carnahan, William "Lacy" Clay, Jr., Jerry Costello, Jo Ann Emerson, Phil Hare, Kenny Hulshof, Ray LaHood, John Shimkus

This report is available at http://www.va.gov/oig/publications/reports-list.asp.