Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00402-16

Combined Assessment Program Review of the Minneapolis VA Medical Center Minneapolis, Minnesota

October 29, 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.

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Executive Summary

Introduction

During the week of August 4–8, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the Minneapolis VA Medical Center (the medical center), Minneapolis, MN. 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 76 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

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

- Screenings for obstructive sleep apnea (OSA) resulted in cost savings and improved care.

We made recommendations in seven of the activities reviewed and had one repeat environment of care (EOC) finding from our prior CAP review. For these activities, the medical center needed to:

- Collect provider-specific performance improvement (PI) data and consider data during reprivileging, in accordance with Veterans Health Administration (VHA) policy.
- Complete peer reviews (PRs) within the timeframes specified in VHA policy and trend and analyze results to identify opportunities for improvement.
- Complete root cause analyses (RCAs) within the timeframe specified in VHA policy.
- Communicate patient complaint data and resulting PI initiatives to senior managers and the Quality Manager, in accordance with VHA policy.
- Perform monthly, randomly scheduled controlled substances (CS) inspections, in accordance with VHA policy.
- Ensure that medical center CS policy includes internal and external notification procedures, in accordance with VHA policy.
- Ensure that staff follow medical center policy regarding medication disposition upon admission.

- Ensure that staff complete intra-facility transfer assessments within the timeframes specified in medical center policy.
- Ensure that provider discharge summaries are consistent with patient discharge orders.
- Correct identified safety and infection control (IC) deficiencies.
- Ensure that patients discharged from the emergency department (ED) receive written discharge instructions.
- Ensure that clinicians document inter-facility transfers in accordance with VHA policy.
- Ensure that managers provide the nursing staff required by the established staffing methodology.

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 CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 18–26, 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 tertiary care facility located in Minneapolis, MN, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at eight community based outpatient clinics in Hibbing, Maplewood, Rochester, and St. James, MN, and in Chippewa Falls, Hayward, Rice Lake, and Superior, WI. The medical center is part of VISN 23 and serves a veteran population of approximately 381,000 throughout the State of Minnesota and 15 counties in Wisconsin.

Programs. The medical center is a teaching hospital with state-of-the-art technology, education, and research. Comprehensive health care is provided through primary care, tertiary care, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The medical center has been designated as one of four VHA Polytrauma Rehabilitation Centers and provides services for severely injured patients. In addition, a new Spinal Cord Injury Center is under construction. The medical center has 279 hospital beds and 80 extended care beds.

Affiliations and Research. The medical center is affiliated with the University of Minnesota and provides residency training in all of the medical, surgical, psychiatric, oral surgery, and diagnostic specialties and subspecialties. The medical center also has formal affiliation agreements with 63 schools to provide allied health training in 36 programs and accredited hospital-based training for radiology technicians, nurse anesthetists, and podiatry and dental residents. More than 1,400 residents, interns, and students were trained at the medical center in 2007.

In fiscal year (FY) 2007, the medical center research program had 635 projects and a budget of approximately $28 million. Important areas of research included heart disease; nutrition; prostate, colon, and hematological malignancies; cholesterol; chronic pain; influenza and pneumonia; diabetes; osteoarthritis; hypertension; Hepatitis C; and chemical dependency. In addition to basic laboratory research, medical center researchers conducted health services studies in smoking cessation, the compensation and benefits process, sexual harassment in

the military, and the implementation of preventative medicine policies.

Resources. FY 2007 medical care expenditures totaled nearly $400 million. The FY 2008 medical care budget was approximately $540 million. FY 2007 staffing was 2,635 full-time employee equivalents (FTE), including 188 physician and 763 nursing FTE.

Workload. In FY 2007, the medical center treated 79,162 unique patients. Acute care workload included 7,786 discharges, an average daily census of 131 patients, and an average length of stay of 6 days. Extended care workload included 618 discharges, an average daily census of 62 patients, and an average length of stay of 37 days. Outpatient workload totaled 593,394 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 eight activities:

- Coordination of Care.
- ED Operations.

- EOC.
- Medication Management.
- Pharmacy Operations.
- QM.
- SHEP.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through August 1, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Minneapolis VA Medical Center, Minneapolis, Minnesota,* Report No. 04-03408-113, March 25, 2005). We had one repeat EOC finding related to refrigerator temperature monitoring from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 76 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. The activity in the "Review Activity Without Recommendations" section has no reportable findings.

Organizational Strength

Screenings Resulted in Cost Savings and Improved Care

OSA, a condition closely linked with the obesity epidemic, is an increasingly recognized and treatable condition associated with significant morbidity and mortality. The medical center met the challenge of rapidly growing demand by implementing an advanced access process utilizing new, more efficient technologies.

Providers screen patients for a high to moderate clinical probability of OSA, and those identified at risk undergo a limited, unattended cardiopulmonary sleep test. If the test is positive, the patient is treated at home with continuous positive airway pressure (commonly known as CPAP)

therapy (average cost is $279). Traditional diagnostic testing in a fully staffed overnight sleep laboratory (average cost is $1,589) is reserved for patients with complex clinical conditions or the very small percentage of patients with high to moderate clinical probability of OSA and non-diagnostic unattended sleep tests.

The medical center's pilot study of this process demonstrated similar clinical outcomes when compared with the traditional approach but had substantial cost savings and reduced waiting times.[1] This study, along with other similar studies, was recently cited by the Centers for Medicare and Medicaid Services as evidence in support of its recent policy change to allow payment for the treatment of OSA based on the results of an unattended sleep study.[2]

After the pilot study, the medical center adopted the process as their standard approach to patients with suspected OSA. The demand for sleep studies in the medical center has increased by more than 500 percent since 2001. Despite the sharp increase in demand, the average waiting time has decreased from 6 months to 6 weeks.

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, Chief of Staff, and Director of Continuous Improvement, and we interviewed other key staff. We evaluated plans, policies, and other relevant documents. Additionally, we followed up on two recommendations from our prior CAP review.

The QM program was generally effective in providing oversight of the medical center's quality of care. Appropriate review structures were in place for 11 of the 15 program areas reviewed. We identified four areas that needed improvement.

[1] Kathryn L. Rice, MD, et al., "Unattended Cardiopulmonary Sleep Studies to Diagnose Obstructive Sleep Apnea," *Federal Practitioner*, Vol. 23, No. 5, May 2006.
[2] Centers for Medicare and Medicaid Services, "Decision Memo for Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)," CAG-00093R2, March 13, 2008.

Credentialing and Privileging. VHA policy requires that the reprivileging process include an appraisal of professional performance, judgment, and clinical/technical competence and skills based in part on provider-specific PI activities. Ongoing reviews are to be conducted by service chiefs and must focus on activities with defined criteria that emphasize the facility's PI plan, appropriateness of care, patient safety, and desired outcomes. We reviewed the credentialing and privileging folders and provider files of 11 randomly selected clinicians who had been reprivileged during the past 2 years. Four (36 percent) of the 11 files did not contain PI data. The data contained in the remaining seven files did not address all of the criteria specified in VHA policy.

Peer Reviews. Once the need for a PR is determined, VHA policy requires that initial reviews be completed within 45 days and that final reviews be completed by the PR Committee within 120 days. Of the 131 PRs completed since October 1, 2007, 11 exceeded the 120-day timeframe.

PR data were trended for outcome levels, level changes, and follow-up action items. However, recommendations that resulted from PRs needed to be trended and analyzed to identify problems or opportunities for improvement.

Root Cause Analyses. VHA policy requires that individual RCAs be completed within 45 calendar days. Of the 12 RCAs completed since July 1, 2007, 1 exceeded the 45-day timeframe.

Patient Complaints. VHA policy requires that patient complaint data and the PI initiatives resulting from the data be communicated at least quarterly to the medical center's Director, Associate Director, Chief of Staff, Nurse Executive, and Quality Manager. Although patient complaint data were presented to the Patient Service Council, the Nurse Executive was the only senior manager on the council. There was no documentation of communication to the remaining senior managers or to the Quality Manager.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that provider-specific PI data be collected and considered during reprivileging, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of Staff's office is

working with the Continuous Improvement Office, the Risk Manager, and patient service line directors to identify additional resources and information for practitioner profiles and to ensure that PI data are included and that VHA criteria are addressed. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that PRs be completed within the timeframes specified in VHA policy and that results be trended and analyzed to identify opportunities for improvement.

The VISN and Medical Center Directors concurred with the findings and recommendation. To ensure timeliness, the PR Coordinator will review the status of PRs monthly and report the findings to the Chief of Staff. The Risk Manager will assist with developing trends and analyzing PR findings to identify opportunities for improvement. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs be completed within the timeframe specified in VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Administrative assistance has been provided to the Patient Safety Manager. Exit appointments will be scheduled with executive leadership. The VISN Patient Safety Officer will oversee the monitoring process and send reminders of due dates. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that patient complaint data and the resulting PI initiatives be communicated to senior managers and the Quality Manager, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Patient Family Center Director will report complaint data and the resulting PI initiatives quarterly to the QM Council and the Patient Service Council. Both committees report to senior managers

through the Executive Leadership Board. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Pharmacy Operations

The purpose of this review was to evaluate whether the medical center had adequate controls to ensure the security and proper management of CS and the pharmacies' internal physical environments. We also assessed whether processes were in place to monitor polypharmacy (patients prescribed multiple medications), especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and CS security, and we assessed whether the medical center's policies and practices were consistent with VHA regulations. We inspected the inpatient and outpatient pharmacies for security, EOC, and IC issues. Additionally, we interviewed the CS Coordinator, pharmacy managers, and VA police officers.

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 treat adverse drug interactions. Elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.

Managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

The medical center had appropriate policies and procedures in place to ensure the security of the pharmacies and CS. The CS Coordinator and CS inspectors were appointed by the medical center's Director and received the training required to execute their duties. The pharmacies' internal environments were secure, clean, and well maintained. We identified two areas that needed improvement.

Controlled Substances Inspections. VHA policy requires that inspectors survey all wards and storage areas containing CS by conducting monthly unannounced CS inspections to ensure the element of surprise. Records showed that inspections of three CS areas were not completed in May, and the inspection of one CS area was not completed in June. We also identified that inspections were generally completed during the latter half of the month, usually during the last week. The CS Coordinator must ensure that all areas are inspected monthly and that inspection dates are randomly scheduled throughout the month.

Policy for Controlled Substances Losses. VHA policy defines procedures to be followed in the event of recurring shortages or losses of significant quantities[3] of CS or if there is an indication of theft. Medical center policy would be strengthened by adding procedures for internal and external notifications that are congruent with VHA policy.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires monthly, randomly scheduled inspections of all CS areas, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The CS Coordinator will review the policy and procedures with inspectors, reinforce the importance of randomized inspections, monitor monthly inspections, and report activities quarterly to the CS Leadership Workgroup. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the medical center CS policy include internal and external notification procedures, in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The CS Leadership Workgroup will update medical center policy to be congruent with VHA notification expectations. The improvement plan is

[3] Defined as "several doses" in VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004.

acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring. We reviewed selected medication management processes in five inpatient units. We found appropriate use of patient armbands to correctly identify patients prior to medication administration. We identified one area that needed improvement.

Medication Disposition Upon Admission. Medical center policy requires that medications brought in by a patient be identified by the physician and, whenever possible, returned to family members or mailed back to the patient's residence. During our inspection of the locked mental health unit, nursing staff reported that they store medications that patients bring from home in a drawer within the secured nurses' station. We found one patient's medication stored on the unit. This storage process is contrary to medical center policy.

Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director requires that staff follow medical center policy regarding medication disposition upon admission.

The VISN and Medical Center Directors concurred with the finding and recommendation. A work group that includes pharmacy, mental health, and regional council staff will determine the appropriate disposition of prescriptions previously held for patients on the mental health unit. Policy will be modified to reflect the determined action plan. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, transfers, and discharges were coordinated appropriately and met VHA and Joint Commission (JC) standards. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process that results in optimal patient outcomes.

We reviewed 12 medical records of inpatients who had consultations ordered and completed internally. We found

that clinicians responded to consultation requests within the timeframes established by VISN and medical center policy. We identified the following areas that needed improvement.

Intra-Facility Transfers. We reviewed 11 medical records of inpatients who transferred between units. Nursing staff from the transferring unit completed appropriate documentation templates for each transfer. Medical center policy requires that staff assess the patient's biophysical parameters within 30 minutes of arrival on the receiving unit. It was difficult to determine if this timeframe was met because nursing staff did not consistently document patient arrival times. We suggested that the assessment template note be revised to include the patient's arrival time on the receiving unit so that compliance with assessment requirements could be determined.

Discharges. We reviewed 12 medical records of inpatients who were discharged from the medical center. Staff provided a copy of the discharge instructions to each of the patients in our sample, and documentation reflected that the patients understood the instructions. However, in 2 of the 12 records, there were inconsistencies between the medications listed in the providers' discharge summaries and those listed in the discharge orders.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete intra-facility transfer assessments within the timeframes specified in medical center policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The Nurse Executive will add a required field on the transfer note to document patient arrival time on the unit. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that provider discharge summaries are consistent with patient discharge orders.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Medical Records Committee will review the discharge summary policy and make recommendations to ensure that discharge summaries are consistent with discharge orders. The committee will

also explore the possibility of hiring a pharmacist to complete medication reconciliation upon a patient's discharge from the mental health unit. Discharge summary templates will be revised to include directions not to import medication lists into the note, and providers will receive education on the process. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the medical center complied with selected IC standards and maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards.

We inspected four inpatient units (extended care, locked mental health, general medicine, and polytrauma), four outpatient clinics (urology, audiology, eye, and mental health), the Veterans Canteen Service (VCS) area, and several common areas. We also followed up on recommendations from our prior CAP review and identified deficiencies in refrigerator temperature monitoring as a repeat finding.

The medical center was generally clean and effectively maintained. Managers and employees were responsive to environmental concerns identified during our inspection, and many of the concerns were resolved while we were onsite.

We evaluated the IC program to determine compliance with VHA directives. IC staff appropriately collected, trended, and analyzed data related to infections, and they involved clinicians in improvement initiatives to reduce infection risks for patients and staff. IC staff also provided in-service education as new health concerns were identified.

The Multidisciplinary Safety Inspection Team conducted monthly EOC rounds of the locked mental health unit and reported discrepancies to management. The medical center met the Deputy Under Secretary for Health for Operations and Management's 2008 EOC performance measures during all quarters reported.

We also determined if the medical center had effective processes in place to ensure that equipment items are properly cleaned and maintained. We selected

16 equipment items and reviewed preventive maintenance (PM) records from Biomedical Engineering. All items had been cleaned in accordance with requirements and had received PM at the recommended intervals. We identified the following areas that required management attention.

Safety. Medications and cleaning products must be secured when not in use. A bottle of medicated eye drops was found on a patient's bedside stand in the locked mental health unit. A bottle of a liquid medication was left on a computer cart in the general medicine unit. Two bottles of bleach were left on a counter top in an unsecured room on the general medicine unit.

Unsecured wooden pallets were placed against a wall in the VCS food service area. These items needed to be relocated to a proper storage area.

Oxygen tanks must be stored so that staff may quickly identify which are full and which are empty. Three of the units we inspected did not have a clear separation between full and empty tanks.

Staff must be prepared to provide quick responses to emergency call systems. We activated the emergency call system in a public restroom immediately outside a patient care unit. Although staff on the unit heard the alarm, there was a delayed response.

On the locked mental health unit, we identified that mirrors in patient restrooms were not shatterproof. Additionally, electrical outlets in patient care areas were not covered or designed to restrict access. Both of these deficiencies could cause injury to patients or staff.

Infection Control. Refrigerators must be monitored daily to ensure that contents are safe. Refrigerator temperature logs on all four inpatient units showed that the refrigerators were out of the acceptable range on select dates. Also, staff did not document corrective actions in the logs. This was a repeat finding from our prior CAP review.

We observed clean, uncovered linen in the hallway on the general medicine unit. Biohazardous trash receptacles and sharps containers were observed in a patient care unit hallway and were not adequately secured to restrict access.

Trash receptacles were uncovered and overflowing in the VCS food service area.

Patient care equipment needs to be regularly inspected, and items with compromised surfaces need to be repaired or removed from service. We observed wheelchairs with cracked armrests and seat surfaces. We were informed that new wheelchairs had been ordered.

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

The VISN and Medical Center Directors concurred with the findings and recommendation. Managers developed comprehensive plans to address each safety and IC deficiency identified during our inspection. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Department Operations

The purpose of this review was to evaluate whether the medical center's ED complied with VHA guidelines related to hours of operation, clinical capability, staffing adequacy, and staff competency. In addition, we inspected the medical center's ED environment for cleanliness and safety.

The medical center's ED is open 24 hours per day, 7 days per week, as required. The ED is located within the main hospital building, and the emergency services provided are within the facility's capability. In addition, the medical center has an appropriate policy for managing patients whose care may exceed the facility's capability. We identified two areas that needed improvement.

Patient Discharge Instructions. We reviewed the medical records of three patients treated and discharged from the ED. Medical center policy requires staff to provide discharge instructions to the patient and/or significant other and to document an evaluation of patient understanding of the instructions. We did not find documentation of discharge instructions for one patient.

Transfer Documentation. We reviewed the medical records of three patients who were initially treated in the ED and then transferred to other hospitals. Clinicians utilized approved VA transfer forms, in accordance with VHA policy. However, during our medical record reviews, we noted omissions of

information on these forms in all three records. Omissions included documentation of the mode of transportation, the signature of the referring physician, time of transfer, acknowledgement of an advanced directive, and the signature of a patient to consent to transfer.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that patients discharged from the ED receive written discharge instructions.

The VISN and Medical Center Directors concurred with the finding and recommendation. ED leadership will evaluate and update the ED policy. ED staff will receive education on ensuring that written discharge instructions are given to patients. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. A power point presentation will be developed for ED staff that will outline expectations for inter-facility transfers. ED leadership will monitor transfers for compliance. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Staffing

The purpose of this review was to evaluate whether the medical center had developed comprehensive nurse staffing guidelines and to determine if the nurse staffing provided corresponded to the medical center's methodology. Identifying and providing the correct number and/or mix of nurses is essential to the delivery of high quality patient care.

Medical center managers utilize hours per patient day (HPPD) as the primary nurse staffing methodology. We reviewed the staffing for five inpatient units for 3 randomly selected dates (1 weekday, 1 weekend day, and 1 holiday). We found that nurse staffing guidelines were met in four of the five units and that specific actions were taken to ensure optimal patient care. One unit did not meet the required staffing guidelines for 2 of the 3 dates (the weekend day and the holiday). Additionally, the unit had not met the required staffing guidelines for the 2 consecutive weekends prior to

and the weekend following the weekend day that was initially reviewed.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that managers provide the nursing staff required by the established staffing methodology.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nurse managers will review HPPD daily, note when staffing is above or below guidelines, and take corrective action as indicated. Chief Nurses will review HPPD reports weekly and make recommendations to the Nurse Executive. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Review Activity Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center uses the results of the quarterly SHEP to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction as "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 medical center's SHEP performance measure results for inpatients and outpatients, respectively.

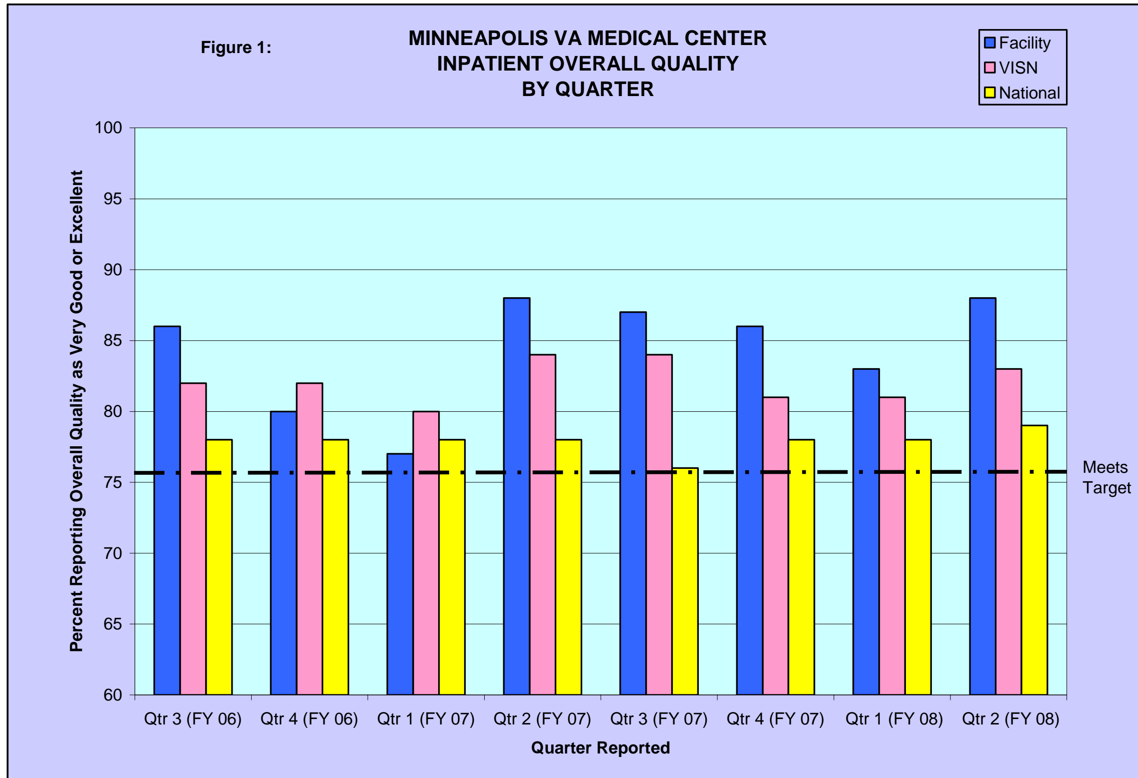
Figure 1:
MINNEAPOLIS VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

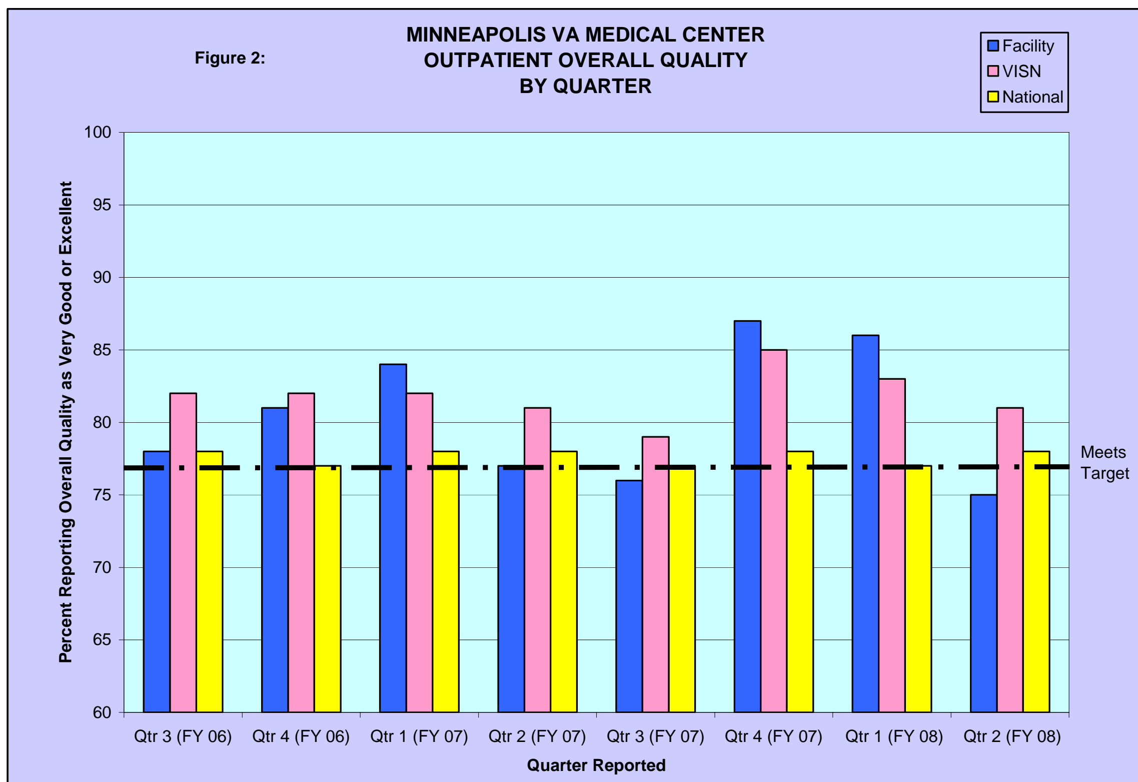
Figure 2:
MINNEAPOLIS VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Meets Target
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Qtr 1 (FY 08)
Qtr 2 (FY 08)
Quarter Reported

The medical center met or exceeded the inpatient target in all 8 quarters of available data and met or exceeded the outpatient target in 6 of the 8 quarters. Managers had identified opportunities for improvement and had initiated an action plan. Because the medical center implemented an action plan, demonstrated evidence of ongoing activities, and evaluated the plan for effectiveness, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2008

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

Subject: **Combined Assessment Program Review of the Minneapolis VA Medical Center, Minneapolis, Minnesota**

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

Director, Management Review Service (10B5)

Concur with the recommendations and planned actions.

ROBERT A. PETZEL, M.D.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2008

From: Medical Center Director (618/00)

Subject: **Combined Assessment Program Review of the Minneapolis VA Medical Center, Minneapolis, Minnesota**

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

Director, Chicago Office of Healthcare Inspections (54CH)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of VAMC Minneapolis (618).

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dated, as detailed in the attached report.

STEVEN P. KLEINGLASS, FACHE

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 provider-specific PI data be collected and considered during reprivileging, in accordance with VHA policy.

Concur **Target Date: September 15, 2009**

The Chief of Staff's office is working with Continuous Improvement, the Risk Manager, and PSL Directors to identify additional resources and information for practitioner profiles to make a more robust performance- based monitoring system in addition to ensuring PI data is included and all criteria in VHA policy are addressed. The initial meeting with the Risk Manager has taken place.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that PRs be completed within the timeframes specified in VHA policy and that results be trended and analyzed to identify opportunities for improvement.

Concur **Target Date: March 15, 2009**

The Peer Review Coordinator is working with the Chief of Staff (COS) to address peer reviewers who have not responded after 30 days. The COS will personally contact the reviewers and make an official request to complete within a 2 day time period. The Peer Review Coordinator will monitor on a monthly basis the status of the completed and outstanding reviews. The Peer Review Coordinator will alert the COS office to take appropriate action to ensure reviews are completed within the established timelines. The recently hired Risk Manager will work to assist in developing trends and analyses of our findings to identify opportunities for improvement. An examination of the Occurrence Screen Program and other tools will be conducted to determine the most efficient and effective methods for completing this process.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs be completed within the timeframe specified in VHA policy.

Concur **Target Date: March 15, 2009**

Improvement in the past year is attributed to administrative assistance for the Patient Safety Manager. Additional action which has been taken to assure sustained compliance with timeliness expectations includes scheduling exit appointments with Executive Leadership and oversight monitoring by the VISN Patient Safety Officer with reminders of upcoming due dates. The Patient Safety Manager will perform monthly monitoring to ensure close out of RCAs within 45 days.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that patient complaint data and the resulting PI initiatives be communicated to senior managers and the Quality Manager, in accordance with VHA policy.

Concur **Target Date: March 15, 2009**

The Patient Family Center Director will present quarterly to Quality Management Council to report complaint data and resulting PI initiatives. In addition, information will also be reported to the Executive Leadership Board senior management on a quarterly basis through both the Patient Service Council and Quality Management Council.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires monthly, randomly scheduled inspections of all CS areas, in accordance with VHA policy.

Concur **Target Date: March 15, 2009**

The Controlled Substance Coordinator has reviewed the policy and procedures with the inspectors. Since April 2008, additional research and clinical areas have been added to the random inspection audit. All inspections were complete for August 2008. The Controlled Substance Coordinator will reinforce the importance of randomized inspections and will consider developing a schedule to assist in randomizing inspections. Inspections will be monitored monthly by the Controlled Substance Coordinator and reported quarterly to the Controlled Substance Leadership Workgroup.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the medical center CS policy includes internal and external notification procedures, in accordance with VHA policy.

Concur **Target Date: March 15, 2009**

The Controlled Substance Leadership Workgroup (Nurse Executive, Chief of Pharmacy, Pharmacy Supervisors, Compliance Officer, Hospital Police,

and Controlled Substance Coordinator) will review the medical center policy and VHA Handbook 1108.1 to assure compliance in notification of discrepancies, diversions, and suspected thefts. Medical center policy will be updated to reflect appropriate adherence to VHA Handbook 1108.1.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that staff follow medical center policy regarding medication disposition upon admission.

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

The targeted area of mental health has identified potential issues with disposal of patient medications. The facility recognizes that there are unique situations creating challenges in returning medications to the patient such as homelessness, potential medication stockpiling, and a further need for physician evaluation of the risks and/or safety concerns of returning medications to patients when suicidal history or medication abuse issues are present. A work group will convene to include pharmacy, mental health staff, and Regional Council to determine the appropriate disposition of previous prescriptions for patients on the mental health unit. The policy will be reviewed and modified to reflect the determined action plan.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete intra-facility transfer assessments within the timeframes specified in medical center policy.

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

The Nurse Executive will review the transfer note and add a required field to document the patient arrival time on the unit and to ensure compliance with medical center policy.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that provider discharge summaries are consistent with patient discharge orders.

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

The COS office has directed the Medical Records Committee to review the discharge summary policy and make recommendations to ensure discharge summaries are consistent with patient discharge orders. Medical Records Committee will explore the potential to hire a pharmacist to complete medication reconciliation upon discharge from the mental health unit (this service exists in other PSLs). The Medical Records Committee will determine the most accurate source of information for discharge medications, and will consider the Pharmacy Medication

Management Discharge Note as the most accurate source. The discharge summary templates will be revised to include directions not to import any medication lists into the note. Education to providers will be offered at the Executive Committee of Medical Staff (ECMS) meeting.

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

Concur **Target Dates: Listed Below**

Please note that responses to Recommendation 10 are divided by two areas noted as requiring management attention: 1) Safety and 2) Infection Control.

1) <u>Safety</u>.

a) Medications and cleaning products must be secured when not in use. A bottle of medicated eye drops was found on a patient's bedside stand in the locked mental health unit. A bottle of a liquid medication was left on a computer cart in the general medicine unit. Two bottles of bleach were left on a counter top in an unsecured room on the general medicine unit.

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

The Nurse Executive will work with the Chief Nursing staff to develop a monitoring tool for Nurse Managers to utilize in addressing potential medications and/or cleaning products that are unsecured during non-use times. This tool would be completed monthly and submitted to the Nurse Executive through the Chief Nurses. Based on future compliance, the frequency for completion of the tool may be reduced to quarterly.

b) Unsecured wooden pallets were placed against a wall in the VCS food service area. These items needed to be relocated to a proper storage area.

Concur **Target Date: September 10, 2008 (Completed)**

The wooden pallets placed against the wall in the food service area were removed on the day of the inspection. Since then the area has been monitored and is in compliance. Monitoring will continue on a weekly basis.

c) Oxygen tanks must be stored so that staff may quickly identify which are full and which are empty. Three of the units we inspected did not have a clear separation between full and empty tanks.

Concur **Target Date: January 1, 2009**

The Facility Logistics Manager will review each storage location. A color coded system will be used to communicate the status of the cylinders in the storage area. Facility Logistics Manager will assign staff to paint cylinder racks green that hold full tanks (gauge not in red zone), paint cylinder racks red that hold empty tanks (gauge in red zone), and install and/or replace 'Full' and 'Empty' signs above the racks as appropriate. Unit staff will receive education on the proper storage of cylinders.

d) Staff must be prepared to provide quick responses to emergency call systems. We activated the emergency call system in a public restroom immediately outside a patient unit. Although staff on the unit heard the alarm, there was a delayed response.

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

Staff in the targeted area (the hallway outside of the locked inpatient mental health unit 1K near the visitor bathroom) will receive education/instructions on how to respond if/when the bathroom alarm is activated. These staff will not be expected to provide medical intervention if not trained, yet staff will be available to offer assistance until medical intervention is provided. Unit 1K staff will provide as needed medical assistance and will be educated on response actions.

e) On the locked mental health unit, we identified that mirrors in patient restrooms were not shatterproof. Additionally, electrical outlets in patient care areas were not covered or designed to restrict access. Both of these deficiencies could cause injury to patients or staff.

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

Mental Health Leadership is working with Engineering Service to address both potential patient safety issues on the locked inpatient mental health unit. Shatterproof mirrors have been ordered and will be installed to ensure patient safety. All electrical outlets in the locked inpatient mental health unit have been inspected by Engineering Service. Under direction from VHA's National Center for Patient Safety, Engineering Service will use ground fault circuit interrupters on all outlets that have not already been grounded to ensure patient safety.

2) Infection Control.

a) Refrigerators must be monitored daily to ensure that contents are safe. Refrigerator temperature logs on all four inpatient units showed that the refrigerators were out of the acceptable range on select dates. Also, staff did not document corrective actions in the logs. This was a repeat finding from our prior CAP review.

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

The Nurse Executive will develop a monitoring tool for use by nursing staff to address the issue of maintaining consistent refrigerator temperature. This tool would be completed weekly and submitted to the Nurse Executive through each service line Chief Nurse. Corrective action will be documented in accordance with policy. This level of monitoring will remain in place until the new centralized temperature control system is installed (date is not determined at the time of this report).

b) We observed clean, uncovered linen in the hallway on the general medicine unit. Biohazardous trash receptacles and sharps containers were observed in the patient care unit hallway and were not adequately secured to restrict access. Trash receptacles were uncovered and overflowing in the VCS food service area.

Note the area below was split into three parts due to varying timelines.

Concur **Target Date: August 20, 2008 (Completed)**

The clean linen room was under construction at the time of the OIG CAP review, in which case linens were located temporarily in the hallways. Since the inspection, the room has been released to the facility again, and the linens have been moved back into the clean linen room.

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

All biohazardous receptacles and filled sharps containers throughout the facility are located in soiled utility rooms, which are locked to prevent patient access. The location of these bins and containers found by the OIG is ward 3F, which is under construction. The supervisor of Unit B has been tasked to reassess the placement of these containers and to work with nursing staff to see if other alternatives are available during construction. Both will be returned to the soiled utility room upon completion of construction.

Concur **Target Date: September 5, 2008 (Completed)**

Housekeeping has increased its daily trash pick-up in the VCS food service area from two to four daily pick-ups. The extra pick-up times were added during peak hours, which occur from 11 a.m. to 1 p.m. The current fiberglass storage containers have lids on them, and staff have been educated on the importance of keeping the lid closed after trash has been disposed of into the container. Daily monitoring has been implemented.

c) Patient care equipment needs to be regularly inspected, and items with compromised surfaces need to be repaired or removed from

service. We observed wheelchairs with cracked armrests and seat surfaces. We were informed that new wheelchairs had been ordered.

Concur **Target Date: September 10, 2008 (Completed)**

The medical center has received 200 new wheelchairs during late August and early September 2008. The new wheelchairs have an identification (RFID) tag attached for locating, maintenance, and cleaning purposes. If a chair requires repair, VA staff enter a work order in VISTA, and the chair is sent to Engineering. Engineering Service will either repair it or issue the wheelchair for disposal.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that patients discharged from the ED receive written discharge instructions.

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

The ED leadership will evaluate and update the ED policy. All staff and moonlighters in ED will be educated on the ED policy to include direction that all patients discharged from ED will receive written discharge instructions from their discharge nurse.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that clinicians document inter-facility transfers in accordance with VHA policy.

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

All ED staff to include moonlighters will be educated on ED policies as mentioned in Recommendation 11. The plan for the ED is to develop a power point presentation that can be sent electronically to all moonlighters and staff physicians specifically outlining how to complete an inter-facility transfer. ED leadership will audit the transfers monthly for compliance.

Recommendation 13. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that managers provide the nursing staff required by the established staffing methodology.

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

The Nurse Executive and Chief Nurses will move to daily HPPD availability for Nurse Manager review. This requires input on each shift of nurse-hours which will require Charge Nurse education. Nurse Managers will review daily HPPD and note when staffing is above or below guidelines and take corrective action as indicated. Chief Nurses will review HPPD reports from Nurse Managers on a weekly basis and will make recommendations for change to the Nurse Executive.

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