Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02836-66

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

February 4, 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 October 22–26, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Harry S. Truman Memorial Veterans' Hospital (hereafter referred to as the medical center), Columbia, 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 212 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strengths and reported accomplishments:

- Fast Track Cancer Consult.
- Joint Incentive Programs.

We made recommendations in three of the activities reviewed; one was a repeat recommendation from the prior CAP report. For these activities, the medical center needed to:

- Consistently review and discuss all QM review activities and take actions on identified opportunities for improvement.
- Complete peer reviews within 120 days.
- Complete root cause analyses (RCAs) within 45 days.
- Monitor moderate sedation in all areas where it is administered.
- Lock medication carts when not in use and date multiple dose medication vials.
- Secure sharps containers.
- Lock the emergency room (ER) supply room.
- Perform temperature checks for patient nutrition and medication refrigerators.
- Resolve environmental vulnerabilities for the locked inpatient psychiatric unit.

- Perform periodic reviews of all business rules, update rules to comply with Veterans Health Administration (VHA) policy, and delete business rules no longer in use.

The medical center complied with selected standards in the following two activities:

- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and James Seitz, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–20, for the full text of the Directors' comments.) We will follow up on the 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 general medical and surgical facility located in Columbia, MO, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Fort Leonard Wood, Kirksville, Camdenton, Saint James, and Mexico, MO. The medical center is part of VISN 15 and serves a veteran population of about 113,000 in 44 counties in central Missouri and 1 county in western Illinois.

Programs. In addition to primary care, the medical center provides highly specialized medical and surgical care, mental health services, physical rehabilitation, transitional care, geriatric services, and hospice care. The medical center has 78 hospital beds, 28 long-term care beds, and 8 residential Compensated Work Therapy Program beds.

Affiliations and Research. The medical center is affiliated with the University of Missouri-Columbia (MU) School of Medicine and provides training for 77 residents and medical students. Affiliations with other MU programs and educational institutions provide training opportunities for other allied health disciplines. In fiscal year (FY) 2007, the medical center research program had 69 active research programs with funding of approximately $6.5 million. Important areas of research include development of new radiopharmaceuticals, diagnostic imaging, cancer therapy, cardiovascular disease, diabetes, pulmonary care, arthritis rehabilitation, and health services.

Resources. In FY 2007, medical care expenditures totaled $184.4 million (the budget was $184.8 million). FY 2007 staffing was 938 cumulative full-time employee equivalents (FTE), including 49 physician and 319 nursing FTE.

Workload. In FY 2007, the medical center treated 30,326 unique patients and provided 16,512 inpatient days in the hospital and 12,325 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 3,428 discharges, and the average daily census, including nursing home patients, was 81. Outpatient workload totaled 282,064 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 five activities:

- Business Rules.
- Environment of Care (EOC).
- QM.
- SCIP.
- SHEP.

The review covered medical center operations for FY 2006 and FY 2007 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri,* Report No. 05-00082-198, September 9, 2005). We had one repeat finding in an EOC activity from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 212 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 Strengths

Fast Track Cancer Consult

All newly diagnosed curable cancers (based on clinical judgment) are followed through the Columbia – Fast Track Cancer Consult program, with a goal of treatment within 4 weeks of diagnosis. The appropriate clinician is contacted via telephone and advised of the fast track consult. Either the attending physician or fellow is required to initiate action within 3 business days and to complete action in 7 business days.

If no action is taken after 4 business days, Performance Improvement (PI) staff contact the Director of Primary Care Service Line, who reviews any cases deemed to have exceptional circumstances. This expedites the treatment process. PI staff track the progress of the consult until definitive therapy is achieved.

Of the 162 cases referred for consult in FY 2007, 128 (79 percent) were deemed appropriate. Of those 128 cases, 120 (94 percent) met the timeline for completion in 7 days, and 81 (63 percent) resulted in the patient being treated with surgery, chemotherapy, or radiation therapy.

Joint Incentive Programs

Joint incentive programs are a precursor of seamless transition services and allow the medical center to provide mental health care for veterans and active duty service/family members onsite at the military base at Fort Leonard Wood, MO. The full continuum of mental health services can be provided to active duty service members and their families prior to discharge from the military.

The medical center has two of the five approved mental health Joint Incentive Fund programs in the country. The programs utilize both telemental health services and onsite counselors to provide care. Telemental health service for Fort Leonard Wood is provided through an existing CBOC. VA employees who are co-located within Behavioral

Medicine at the Fort Leonard Wood military hospital provide onsite mental health counseling.

These programs increase mental health access for Fort Leonard Wood and the CBOC, allow early mental health intervention with "future" veterans, create a potential for the seamless transition of mental health care from the Department of Defense (DoD) to the medical center, and create a positive experience for soldiers returning from combat. These programs benefit DoD by allowing access to mental health services within 14 days, decreasing referrals to the Tricare network, and increasing capacity for mental health services in rural areas.

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 senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 10 of the 14 program activities reviewed. We identified four areas that needed improvement.

Clinical Executive Board Oversight of Quality Management Data. The medical center had implemented several quality improvement initiatives, but there was a lack of consistent documentation of discussion and analysis of QM data and of actions taken to improve processes. The Clinical Executive Board (CEB) is responsible for ensuring that medical staff monitors are appropriately conducted and that proper follow-up actions are performed regarding problems and proposed recommendations arising from reviews. A CEB reporting matrix specifies committee minutes and reports that the CEB is required to review on a monthly basis. Although mortality and utilization management data were listed as monthly review requirements, CEB minutes did not document reporting, discussion, or actions. The Medical

Record Review Committee and the Blood Usage Review Committee had referred identified issues to the CEB that required action, but the CEB had not implemented corrective actions.

Peer Reviews. The peer review process included all VHA required components but did not meet the timeliness requirements of completion within 120 days. Peer review is a protected, non-punitive, medical center process to evaluate the quality of care at the provider level. The peer review process includes an initial review by a peer of the same discipline to determine if most experienced, competent practitioners would have managed the case in a similar fashion or if most experienced, competent providers would have managed one or more aspects of the care differently.

The initial review must be completed within 45 days from the determination that a review is necessary. Once this is complete, the peer review is then forwarded to a multidisciplinary peer review committee for validation of, or changes to, the initial findings. This is to be completed within 120 days from the determination that a review is necessary. The results are then shared with the involved provider in order to provide feedback about his/her practice. Peer reviews can result in both immediate and long-term improvements in patient care by impacting individual providers' practices.

The medical center's FY 2007 peer review days to completion data showed an average of 162 days, with 2 quarters averaging greater than 180 days. When peer review feedback is delayed, opportunities to improve practice can be missed.

Root Cause Analysis. The RCA process is used to identify contributing causes of variations in care associated with adverse events. VHA policy requires that RCAs be completed and forwarded to the National Center for Patient Safety (NCPS) within 45 days of the team charter. The NCPS must approve any requests to extend the time requirement.

Of the five RCAs we reviewed, the medical center had completed only one in the required timeframe. The Patient Safety Manager was aware of the timeliness issue and had

recently implemented a timeline tracking tool with defined times for completion of various steps of the RCA process.

Moderate Sedation. Moderate sedation is a form of drug-induced depression of consciousness used to decrease pain and anxiety and to improve comfort for patients undergoing procedures or diagnostic treatments. Because of potential risk, VHA requires the monitoring of compliance with defined protocols in all areas where moderate sedation is given.

The Operative and Invasive Procedure Committee is the local oversight committee for analyzing data related to moderate sedation. Anesthesiology, Cardiology, and Radiology had not submitted quarterly reports to the committee for the last 12 months.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that the CEB consistently review and discuss all QM review activities and take actions on identified opportunities for improvement.

The VISN and Medical Center Directors concurred with our findings and recommendation. A reporting matrix outlines when review activities will be submitted to the oversight committee for discussion. This process will be monitored for compliance. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director require that the Medical Center Director ensures that peer reviews are completed within 120 days.

The VISN and Medical Center Directors concurred with our findings and recommendation. PI staff track peer reviews for timeliness and report any that exceed 120 days to the PI Manager, service line Directors, and the Chief of Staff for appropriate action. We find this plan appropriate and will follow up on reported implementation actions to ensure compliance.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director monitors the timeliness of RCA completion for compliance with the 45-day timeframe.

The VISN and Medical Center Directors concurred with our findings and recommendation. The Patient Safety Manager has established a timeline for tracking RCA completion that has improved timeliness. We find this action plan appropriate and will follow up on reported implementation actions to ensure continued compliance.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director implements a process for monitoring moderate sedation.

The VISN and Medical Center Directors concurred with our findings and recommendation. Results from moderate sedation reviews will be reported to the CEB. We find this plan appropriate and will follow up on reported implementation actions to ensure compliance.

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control (IC) standards and maintained a clean and safe patient care environment. Medical centers are required to establish a comprehensive EOC program that fully meets NCPS, Occupational Safety and Health Administration (OSHA), and Joint Commission standards.[1]

We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for patients and staff.

We conducted onsite inspections of ambulatory care areas, inpatient units, the ER, the NHCU, ambulatory surgery, the post-anesthesia care unit, and the locked inpatient psychiatric unit. Staff and nurse managers expressed high satisfaction with the responsiveness of the housekeeping staff on their units. We found that the medical center maintained a generally clean and safe environment.

Medical center managers conducted quarterly mental health EOC assessments for the locked inpatient psychiatric unit, as required by VHA. Additionally, the medical center asked the NCPS Program Manager to review the locked inpatient

[1] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

psychiatric unit for potential safety issues. That review noted several opportunities to improve the unit. The medical center Director told us that beginning in December 2007, the unit would undergo major renovation that will correct deficiencies.

We identified five safety concerns that needed improvement.

Medication Management. On an inpatient unit, we found an unlocked medication cart and one multiple dose medication vial that did not have a date indicating when the vial was opened. Medical center policy requires that medication carts be locked when not in use. Open access to the cart posed a danger to patients and visitors. We interviewed an ambulatory care nurse who stated that multiple dose medication vials are usable for 30 days. However, medical center policy requires that vials be marked with the date they are opened and discarded after 28 days. Without an open date and knowledge of policy, nurses would not know when they need to discard the vials.

Sharps Containers. We found four unsecured sharps containers on shelves or desks in four different clinical areas. OSHA blood borne pathogen regulations state that containers for contaminated sharps must be upright throughout use. Since these containers were unsecured, they could easily tip over, resulting in spillage of contaminated needles and syringes.

Supply Security. An ER supply room door, equipped with an automatic locking mechanism and keyless entry, was propped open. The room contains clean linens and supplies. Because the room is adjacent to an outside entrance, contamination and theft of supplies could easily occur.

Refrigerator Temperature Checks. We found that 5 of 17 refrigerators (29 percent) did not have daily temperature checks completed. Medical center policy requires that all patient nutrition and medication refrigerators have temperatures monitored on a daily basis and that a temperature log be kept for each refrigerator. If staff do not monitor the refrigerator temperatures for the acceptable range, patient food could become contaminated, and medication could be damaged and unusable. This was a repeat finding from the previous CAP review.

Locked Inpatient Psychiatric Unit Environment. We found two bathroom mirrors that could be removed and potentially used as weapons. We also validated the medical center's assessment of identified environmental vulnerabilities, including:

- Potential anchor points that could be used for hanging located on (a) partially removed hallway light fixtures, (b) hallway ceilings with removable panels, (c) hallway fire sprinklers that were not breakable or flush to the ceiling, (d) the entrance's hallway closet, (e) door latching hardware, and (f) bathroom fixtures.
- Electrical outlets not covered or grounded.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that nursing staff lock medication carts when not in use and follow local policy regarding multiple dose medication vials.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center includes compliance with local policy as part of their ongoing readiness tracers. Nursing staff are provided feedback and reeducation when the tracer is conducted. The corrective action is appropriate, and we consider this recommendation closed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that sharps containers be secured.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center either mounted or removed sharps containers to comply with requirements. The corrective action is appropriate, and we consider this recommendation closed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires the ER supply room to remain locked at all times.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center reeducated staff regarding security of supplies. Access is

monitored during weekly EOC rounds. The corrective action is appropriate, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that patient nutrition and medication refrigerator temperature checks be completed, as required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center has installed an automatic temperature monitoring system for all medication and nutrition refrigerators. Engineering monitors continual readouts to ensure appropriate temperatures. The corrective action is appropriate, and we consider this recommendation closed.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director resolves environmental vulnerabilities in the locked inpatient psychiatric unit.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center will begin construction in January 2008 to correct inpatient psychiatric unit vulnerabilities. We find the action appropriate and will follow up on reported implementation actions to ensure completion.

Business Rules

The purpose of this review was to determine whether business rules governing the computerized patient record system (CPRS) comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record.

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the combined electronic and paper medical record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed

editing of signed medical records. In accordance with this guidance, OI has recommended that any editing of signed records be limited to a medical center's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center information and technology policies and interviewed medical center Information Technology (IT) staff. Although the medical center had reviewed business rules following issuance of the guidance, we found four rules that were not in compliance with VHA policy. IT staff deleted these rules while we were onsite.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director requires program staff to continue to perform periodic reviews of all business rules, update rules to comply with VHA policy, and delete business rules no longer in use.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center resolved deficiencies during the CAP visit. There is now a process in place for the Clinical Applications Coordinator to review all medical center business rules monthly. The VISN will address issues related to the integrated database. The corrective action is appropriate, and we consider this recommendation closed.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs. In 2005, VHA adopted surgical infection performance measures (PMs) from the Centers for Medicare and Medicaid Services and The Joint Commission into its performance measurement system to improve surgical patient outcomes.

We evaluated the following VHA PMs reported for FY 2006 and quarters 1–3 of FY 2007:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical incision. The time of administration depends on the antibiotics given. The VHA target was 90 percent.
- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed. The VHA target was 87 percent.
- Controlled blood glucose levels for cardiac surgery, which should be maintained below 200 milligrams/deciliter for the first 2 days post-operative. Elevated levels are associated with impaired bactericidal activity of the immune system. The VHA target was 90 percent.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing. The VHA target was 70 percent.

We reviewed medical center PM scores and compared them to VHA established targets. For PMs that fell below VHA targets, medical center managers had developed and implemented acceptable improvement strategies. One initiative included the placement of educational posters in the operating rooms, surgery clinics, and surgeons' rooms. Another initiative involved continuous individual and group training with the goal of reducing surgical infection rates through evidence-based medical practice and standardized patient care. The program managers monitored the efficacy of the improvement strategies and communicated the results to staff.

We reviewed the medical records of 30 patients who had surgery performed during the 3rd quarter of FY 2007. The review included medical records for each of the

following surgical categories: (a) colorectal, (b) vascular, (c) orthopedic (knee or hip replacement), and (d) cardiac. Review results are displayed in the table below.

Antibiotic administered timely	Antibiotic discontinued timely	Blood glucose control (cardiac surgery)	Body temperature control (colorectal surgery)
100 percent (30/30)	100 percent (30/30)	100 percent (15/15)	67 percent (4/6)

Our medical record review supported the improved PM scores, demonstrating that medical center staff appropriately administered and discontinued antibiotics or documented clinical exceptions and that clinicians monitored blood glucose for the first 2 post-operative days for patients who had cardiac surgery performed. Medical center staff had implemented action plans to improve the control of post-operative body temperature for patients who had colorectal surgery performed.

Because we determined that medical center staff had initiated appropriate corrective actions to improve care, we made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system 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 PM results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Figure 1 on the next page shows the medical center's SHEP PM results for inpatients. Figure 2 on the next page shows the medical center's SHEP PM results for outpatients.

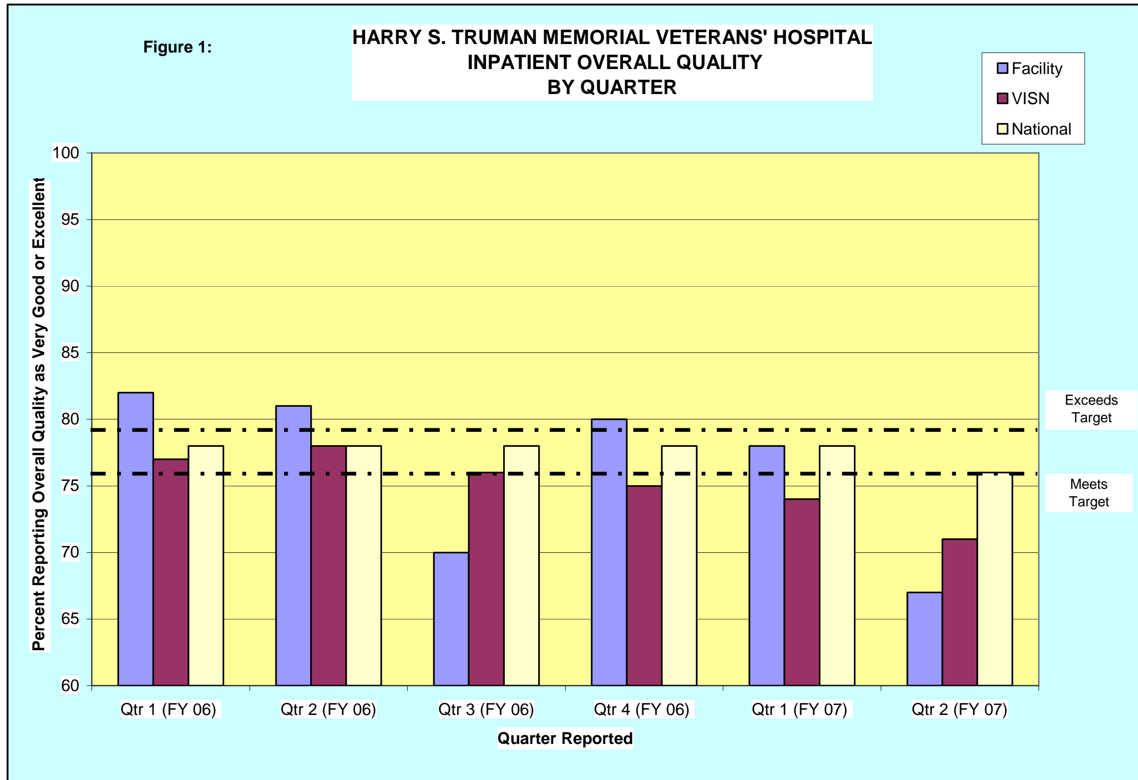


Figure 1:
HARRY S. TRUMAN MEMORIAL VETERANS' HOSPITAL
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Quarter Reported

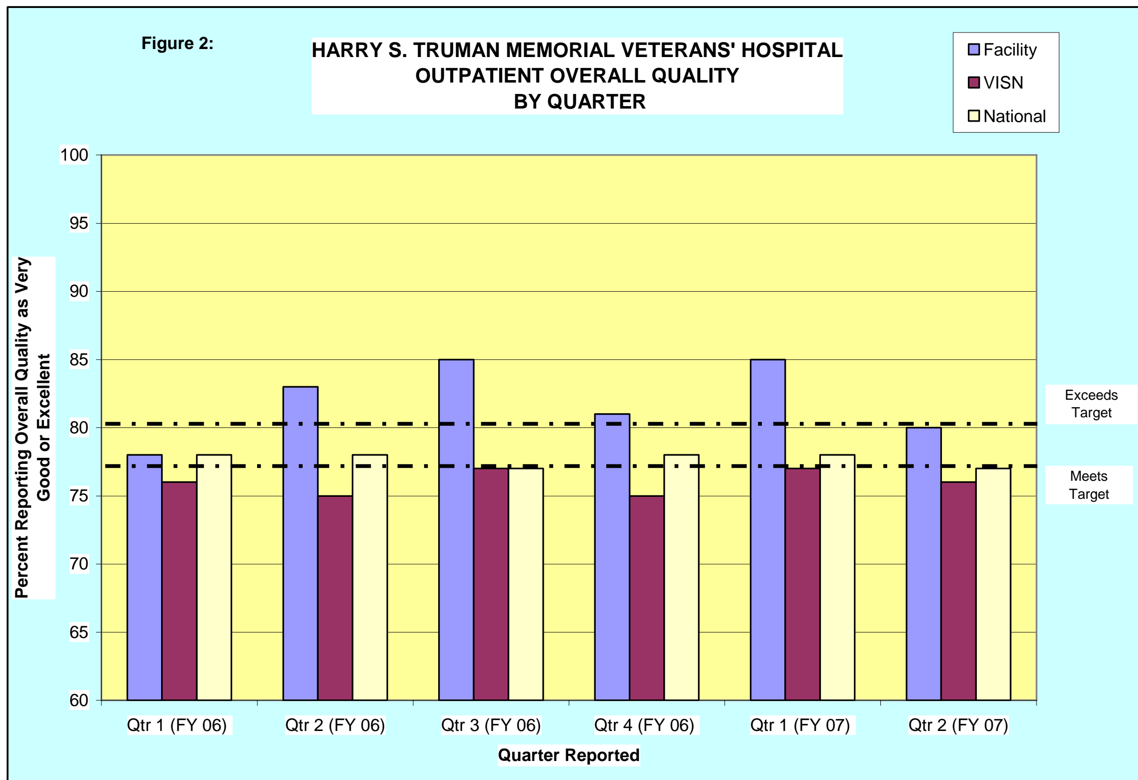


Figure 2:
HARRY S. TRUMAN MEMORIAL VETERANS' HOSPITAL
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Quarter Reported

The medical center exceeded the established target for 4 of the last 6 quarters for inpatient results and all 6 quarters for outpatient results. The medical center has identified opportunities for improvement based on the SHEP scores and has developed an action plan targeting specific services and departments. The action plan has been implemented, and there is evidence of ongoing activities and of evaluation of the plan for effectiveness. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2007

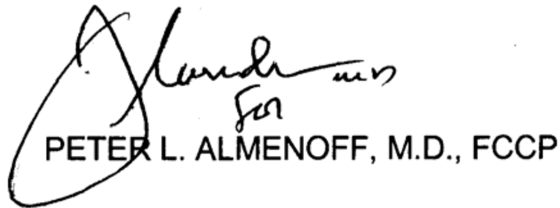
From: Director, Veterans Integrated Service Network (10N15)

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

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

Director, Management Review Service (10B5)

I have reviewed and concur with the responses to the recommendations outlined in this report.



PETER L. ALMENOFF, M.D., FCCP

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2007

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

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

To: Director, Veterans Integrated Service Network (10N15)

1. This is to acknowledge receipt and thorough review of the findings and recommendations of the Office of the Inspector General Combined Assessment Program review conducted October 22–26, 2007. Columbia VAH concurs with the IG findings and the recommendations and appreciates the opportunity to review the draft report. Actions taken are included in our response, and we request that these items be closed.

2. We want to thank all of the people involved in the CAP review. The team members required us to take a critical look at our systems and processes, and we do appreciate the very thorough review and the opportunity to further improve the quality care we provide for our veterans.

Sallie Houser-Hanfelder, FACHE

SALLIE HOUSER-HANFELDER, FACHE
Director

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 the CEB consistently review and discuss all QM review activities and take actions on identified opportunities for improvement.

Concur

Quality Management review activities will be submitted, reviewed, discussed, and monitored in accordance with published reporting matrix, HPM 589A4-77, issued May 15, 2007.

Recommendation 2. We recommended that the VISN Director require that the Medical Center Director ensures that peer reviews are completed within 120 days.

Concur

Performance Improvement staff track peer reviews to meet the established timelines. Peer reviews that exceed 120 days are reported to the Manager, Performance Improvement, appropriate Service Line Director, and Chief of Staff for action.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director monitors the timeliness of RCA completion for compliance within the 45-day timeframe.

Concur

RCA benchmark/timeline was established in June 2007 to meet the 45-day requirements. All four RCA's chartered since implementation of this timeline meet the 45-day requirement.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director implements a process for monitoring moderate sedation.

Concur

Performance Improvement program analyst reviews all moderate sedation administered outside the operating room based on review matrix for both quality of care and documentation. Findings are summarized and forwarded to the Chief, Anesthesia for review of quality of care and reporting to Operative and Invasive Procedure (Surgical Case Review Committee). Documentation findings are provided to Health Information Committee for review and reporting. Findings will be reported to Clinical Executive Board.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that nursing staff lock medication carts when not in use and follow local policy regarding multiple dose medication vials.

Concur

Compliance with local policy for both medication carts and multi-dose vials are included as part of ongoing readiness tracers. Findings are tracked/trended and reported to appropriate Service Line Director and senior management. Feedback and reeducation of staff is provided at the time the tracer is conducted.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that sharps containers be secured.

Concur

Unsecured sharp containers were mounted or removed to meet policy requirements. Monitoring is included in Environment of Care rounds weekly.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires the ER supply room to remain locked at all times.

Concur

Staff were reeducated specific to this recommendation. Monitoring compliance is integrated in Environment of Care rounds and facility readiness tracers.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that patient nutrition and medication refrigerator temperature checks be completed, as required by local policy.

Concur

Temp Track System software was purchased, installed, and is functioning. All medication/nutrition refrigerators are monitored through Engineering Control Center 24/7. When completely rolled out, the system will include all Community Based Outpatient Clinics. This system replaces individual medication/nutrition logs. Appropriate staff are being trained on this new system.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director resolves environmental vulnerabilities in the locked inpatient psychiatric unit.

Concur

A non-recurring project to correct inpatient psychiatric unit vulnerabilities is approved. Construction is scheduled to begin January 7, 2008.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires program staff to continue to perform periodic reviews of all business rules, update rules to comply with VHA policy, and delete business rules no longer in use.

Concur

Deficiencies identified during OIG CAP were resolved at the time of survey. The facility Clinical Applications Coordinator will review all business rules that apply to the facility on a monthly basis, update rules to comply with VHA policy, and delete business rules no longer in use. It should be noted that VISN 15 has an integrated database. This allows any user from any of the five facilities who hold the user class of Clinical Coordinator to edit business rules. Since there is no paper trail, changes could occur without knowledge of local staff. Monthly reviews of TIU business rules should address this potential vulnerability. Additionally, we are seeking input and guidance from the VISN specific to issues related to our integrated database.

OIG Contact and Staff Acknowledgments

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