Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00075-351

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

May 18, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
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Glossary

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

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of March 2, 2015.

Review Results: The review covered nine activities.

Recommendations: We made recommendations in all nine of the following activities:

Quality Management: Ensure the Facility Director continues to chair Quality Executive Board meetings. When cases receive initial Level 2 or 3 ratings, require the Peer Review Committee to consistently invite involved providers to submit comments to and/or appear before the committee. Ensure the Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms. Require that licensed independent practitioners who perform emergency airway management (EAM) have properly approved/signed privilege forms. Ensure licensed independent practitioners' folders do not contain non-allowed information. Implement a policy that defines Surgical Work Group membership, and ensure the group documents its review of National Surgical Office reports and all surgical deaths with identified problems or opportunities for improvement. Report all critical incidents through the adverse event reporting process. Review the quality of entries in the electronic health record and analyze data at least quarterly. Fully implement the new quality control policy for scanning.

Environment of Care: Require that Environment of Care Committee minutes include discussion regarding rounds deficiencies. Ensure patient care areas and public restrooms are clean. Repair damaged furniture in patient care areas, or remove it from service. Store oxygen tanks in a manner that distinguishes between empty and full. Ensure all electrical gang boxes have the appropriate covers installed. Store clean and dirty items separately. Promptly remove outdated commercial supplies from sterile supply rooms. Promptly remove expired medications from patient care areas, and label medications in accordance with local policy. Inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations. Document functionality checks of the community living center's elopement prevention system at least every 24 hours, and conduct and document annual complete system checks. Inspect and tag critical medical equipment in the community living center.

Medication Management: Require that crash cart logs contain the correct lock numbers. Ensure the look-alike and sound-alike medication list and the high-alert medication list are available for staff reference.

Coordination of Care: Create/designate a committee to oversee consult management. Ensure that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the

computerized consult package and that these services designate an individual to review and manage consults. Ensure requestors consistently select the proper consult title.

Magnetic Resonance Imaging Safety: Complete secondary patient safety screenings immediately prior to magnetic resonance imaging (MRI). Require that radiologists and/or Level 2 MRI personnel document resolution of all identified MRI contraindications prior to the scan. Ensure all designated Level 1 ancillary staff and all designated Level 2 MRI personnel receive annual level-specific MRI safety training.

Acute Ischemic Stroke Care: Revise the stroke policy to address a stroke team and data gathering for analysis and improvement, and fully implement the revised policy. Complete and document National Institutes of Health stroke scales for each stroke patient. Collect and report all required data elements to the Veterans Health Administration.

Surgical Complexity: Ensure Radiology Service revises the computed tomography scan, MRI/magnetic resonance angiograms, and radiology interpretation on-call policy to require a 30-minute reporting time.

EAM: Ensure initial clinician EAM competency assessment includes all required elements. Require that clinician reassessment for continued EAM competency is completed at the time of renewal of privileges or scope of practice and includes completion of all required elements at the time of renewal. Ensure clinicians reassessed for continued EAM have a statement related to EAM included in an approved scope of practice. Require that a clinician with EAM privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care. Strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.

Mental Health Residential Rehabilitation Treatment Program: Ensure that only authorized patients, staff, and visitors access the Domiciliary Residential Rehabilitation Treatment Program and that the program does not have closed circuit television in treatment areas.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 31–48, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objective and Scope

Objective

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

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

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

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

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2014 and FY 2015 through March 6, 2015, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA St. Louis*

Health Care System, St. Louis, Missouri, Report No. 12-02188-15, October 29, 2012). We made a repeat recommendation in EOC.

We surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 531 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.	• During FY 2014, the Facility Director did not chair or co-chair the Quality Executive Board. In January 2015, the Interim Facility Director began chairing the board.	**1.** We recommended that the Facility Director continue to chair Quality Executive Board meetings.
X	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.	For the 12-month period May 1, 2013, through April 30, 2014: • For several death cases that received initial Level 2 or 3 ratings, the Peer Review Committee did not invite involved providers to provide input prior to the final determination.	**2.** We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• During FY 2014, the Medical Executive Board did not review privilege forms. • The Medical Executive Board and the Facility Director had not reviewed and approved two revised privilege forms. • Of the seven applicable licensed independent practitioners' folders reviewed, five practitioners' EAM privilege forms were not properly approved/signed. • All 10 licensed independent practitioners' folders contained non-allowed information.	**3.** We recommended that the Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms and document the review. **4.** We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have properly approved/signed privilege forms. **5.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	Nine months of Surgical Work Group meeting minutes reviewed: • There was no policy defining membership, and the Acting Chief of Staff did not attend consistently. • The group did not document review of National Surgical Office reports. Several surgical deaths that occurred October 1, 2013–July 30, 2014, had identified problems or opportunities for improvement: • The Surgical Work Group did not document its review of any of these deaths.	**6.** We recommended that the facility implement a policy that defines Surgical Work Group membership. **7.** We recommended that the Surgical Work Group document its review of National Surgical Office reports and its review of all surgical deaths with identified problems or opportunities for improvement.
X	Clinicians appropriately reported critical incidents.	• During FY 2014, some critical incidents occurred that were not reported through the required process.	**8.** We recommended that clinicians report all critical incidents through the facility's adverse event reporting process.
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	• During FY 2014, the Medical Records Review Committee did not review the quality of entries in the EHR and analyze data quarterly.	**9.** We recommended that the facility review the quality of entries in the electronic health record and analyze data at least quarterly.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors. • A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.	• The February 28, 2011, scanning policy did not include an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure readability and retrievability, and quality assurance reviews on a sample of the scanned documents. In 2015, the facility implemented a new policy that contains all the required elements.	**10.** We recommended that the facility fully implement the new quality control policy for scanning and that facility managers monitor compliance.
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

At the John Cochran division, we inspected critical care (medical intensive care unit and surgical intensive care unit), the Emergency Department, inpatient units (medicine, MH, progressive care, surgical, and spinal cord injury), and primary care and specialty care clinics. At the Jefferson Barracks division, we inspected the CLC, the spinal cord injury unit, the podiatry clinic, and primary care clinics. Additionally, we reviewed relevant documents, including inspection documentation for 10 alarm-equipped medical devices in critical care, and 40 employee training records (20 critical care and 20 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not include discussion regarding EOC rounds deficiencies.	**11.** We recommended that Environment of Care Committee minutes include discussion regarding environment of care rounds deficiencies and that facility managers monitor compliance.
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility met environmental safety requirements.	• Two of 11 patient care areas contained dirty floors and dust on horizontal surfaces. • Two public restrooms had dirty blinds, grout, floors, walls, and vents. • Three of 11 patient care areas contained damaged furniture. • Two of 11 patient care areas contained oxygen tanks that were not stored in a manner that distinguished between empty and full tanks. This was a repeat finding from the previous CAP review. • On the progressive care unit, one electrical gang box did not have the appropriate cover installed.	**12.** We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance. **13.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service. **14.** We recommended that the facility store oxygen tanks in a manner that distinguishes between empty and full tanks and that facility managers monitor compliance. **15.** We recommended that facility managers ensure all electrical gang boxes have the appropriate covers installed.
X	The facility met infection prevention requirements.	• Three of 11 patient care areas had clean and dirty items stored together. • Two sterile supply rooms contained outdated commercial supplies.	**16.** We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance. **17.** We recommended that the facility promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance.
X	The facility met medication safety and security requirements.	• Two of 11 patient care areas contained expired medications.	**18.** We recommended that the facility promptly remove expired medications from patient care areas and that facility managers monitor compliance.
	The facility met privacy requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on medication management within the facility reviewed: • Four patient care areas contained opened multi-dose vials with beyond-use dates greater than the 28 days required by local policy. • Two patient care areas contained multi-dose medications without the beyond-use date on the label. • Two patient care areas had pharmacy prepared medications without expiration dates.	**19.** We recommended that the facility label medications in accordance with local policy and that facility managers monitor compliance.
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
X	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.	• The facility did not annually inspect/check three of five alarm-equipped medical devices on the surgical intensive care unit and two of five on the medical intensive care unit as required by local policy and the manufacturers.	**20.** We recommended that the facility inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations and that facility managers monitor compliance.
	The facility met fire safety requirements in critical care.		
X	The facility met environmental safety requirements in critical care.	• Two public restrooms had dirty floors, grout, partitions, walls, and vents. • On the surgical intensive care unit, one electrical gang box did not have the appropriate cover installed.	See recommendations 12 and 15.
	The facility met infection prevention requirements in critical care.		

NM	Areas Reviewed for Critical Care (continued)	Findings	Recommendations
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on medication management within the facility reviewed: • An opened multi-dose medication did not have the beyond-use date on the label.	See recommendation 19.
	Areas Reviewed for CLC		
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
X	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.	• The facility did not consistently document functionality checks of the CLC elopement prevention system at least every 24 hours. • The facility did not have evidence of an annual complete system check of the CLC elopement prevention system.	**21.** We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and conduct and document annual complete system checks and that facility managers monitor compliance.
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		

NM	Areas Reviewed for CLC (continued)	Findings	Recommendations
X	The facility met medical equipment requirements in the CLC.	• One critical medical equipment item in the CLC did not have an inspection tag, and two had expired inspection tags.	**22.** We recommended that the facility inspect and tag critical medical equipment in the community living center and that facility managers monitor compliance.
	The facility met privacy requirements in the CLC.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on medication management within the facility reviewed: • The CLC contained an opened multi-dose vial without the beyond-use date on the container.	See recommendation 19.
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

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

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

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
X	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.	• One emergency crash cart log contained incorrect lock numbers.	**23.** We recommended that facility managers ensure crash cart logs contain the correct lock numbers and monitor compliance.
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.	• Three of four areas did not have the look-alike and sound-alike medication list available for staff reference.	**24.** We recommended that the facility ensure the look-alike and sound-alike medication list is available for staff reference in all areas.
X	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.	• The facility's high-alert medication list was not available for staff reference.	**25.** We recommended that the facility ensure the high-alert medication list is available for staff reference.
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

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

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 37 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	A committee oversaw the facility's consult management processes.	• The facility did not have a committee to oversee consult management.	**26.** We recommended that the facility create/designate a committee to oversee consult management.
X	Major bed services had designated employees to: • Provide training in the use of the computerized consult package. • Review and manage consults.	• The Medicine, MH, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators did not provide training in the use of the computerized consult package. • Medicine, MH, Surgical, and Rehabilitation Services had not designated an individual to review and manage consults.	**27.** We recommended that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance. **28.** We recommended that Medicine, Mental Health, Surgical, and Rehabilitation Services designate an individual to review and manage consults.
X	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.	• Eight consult requests (22 percent) did not include "inpatient" in the title.	**29.** We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

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

MRI Safety

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

We reviewed relevant documents and the training records of 45 employees (30 randomly selected Level 1 ancillary staff and 15 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of the MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Eighteen EHRs (51 percent) did not contain secondary patient safety screenings prior to MRI.	**30.** We recommended that the facility complete secondary patient safety screenings immediately prior to magnetic resonance imaging and that facility managers monitor compliance.
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Four of the applicable six EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**31.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.	• Three Level 1 ancillary staff (10 percent) did not receive level-specific annual MRI safety training. • Four Level 2 MRI personnel did not receive level-specific annual MRI safety training.	**32.** We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance. **33.** We recommended that the facility ensure all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

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

We reviewed relevant documents and the EHRs of 45 patients who experienced stroke symptoms, and we conversed with key employees. We also conducted onsite inspections of the CLC, the Emergency Department, two critical care units, and eight inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility's policy did not address: o A stroke team o Data gathering for analysis and improvement	**34.** We recommended that the facility revise the stroke policy to address a stroke team and data gathering for analysis and improvement and that facility managers fully implement the revised policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For 15 of the 40 applicable patients (38 percent), clinicians did not document evidence of completion of stroke scales.	**35.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
NA	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.		
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.		
	Clinicians provided printed stroke education to patients upon discharge.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The facility provided training to employees involved in assessing and treating stroke patients.		
X	The facility collected and reported required data related to stroke care.	• The facility did not collect and/or report the following data to VHA: o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake	**36.** We recommended that the facility collect and report to the Veterans Health Administration the percent of patients with stroke symptoms who had the stroke scale completed and the percent of patients screened for difficulty swallowing before oral intake.
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

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

We reviewed relevant documents and the training records of six employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.	• Radiology Service's policy did not clearly specify that employees on call for computed tomography scans, MRI/magnetic resonance angiograms, and radiology interpretation must report within 30 minutes.	**37.** We recommended that Radiology Service revise the computed tomography scan, magnetic resonance imaging/magnetic resonance angiograms, and radiology interpretation on-call policy to require a 30-minute reporting time.
	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.		
NA	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

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

We reviewed relevant documents, including competency assessment documentation of 12 clinicians applicable for the review period January 1–June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
X	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients	• Neither of the two applicable clinicians with initial EAM competency assessments had documentation of all required elements.	**38.** We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• Five of the 10 applicable clinicians did not have reassessments for continued EAM competency completed at the time of renewal of privileges or scope of practice. • Four of the 10 applicable clinicians did not have documentation of all required elements completed at the time of renewal of privileges or scope of practice. • None of five clinicians with reassessments for continued EAM scope of practice had a statement related to EAM included in an approved scope of practice.	**39.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance. **40.** We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance. **41.** We recommended that the facility ensure that clinicians reassessed for continued emergency airway management have a statement related to emergency airway management included in an approved scope of practice.
X	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.	• None of the 30 sampled days had appropriate EAM coverage during all hours the facility provided patient care.	**42.** We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on EAM reviewed, which requires a root cause analysis when a clinician without EAM privileges performs an intubation: • The facility had two instances when non-privileged clinicians performed intubations, and there was no documentation of a root cause analysis.	**43.** We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.

MH RRTP

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

We reviewed relevant documents, inspected the Domiciliary and Substance Abuse RRTP, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

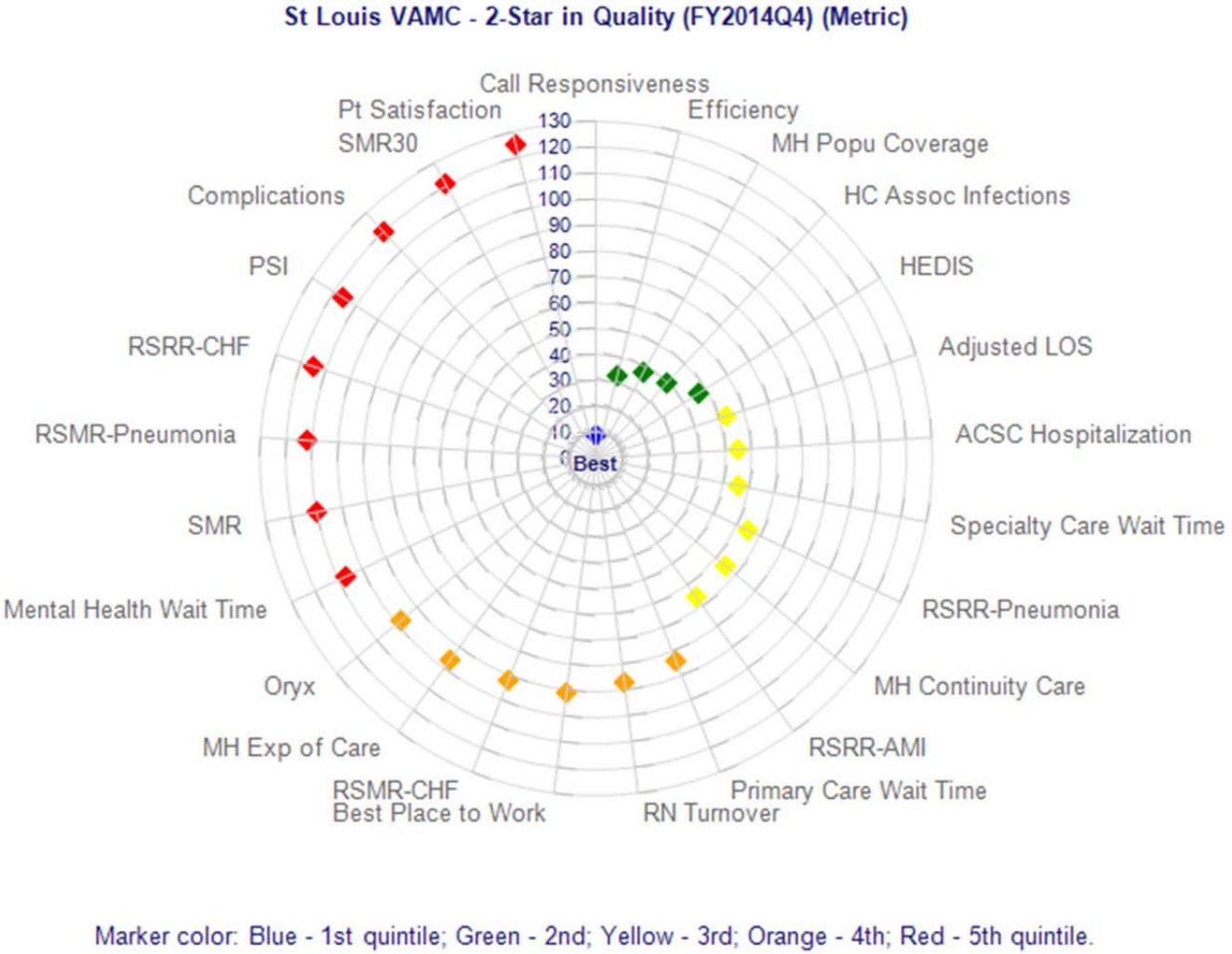
NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
X	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• The Domiciliary RRTP did not have a consistently secure main point of entry.	**44.** We recommended that facility managers ensure that only authorized patients, staff, and visitors access the Domiciliary Residential Rehabilitation Treatment Program.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.	• The Domiciliary RRTP had closed circuit television in treatment areas.	**45.** We recommended that facility managers ensure that the Domiciliary Residential Rehabilitation Treatment Program does not have closed circuit television in treatment areas.
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (St. Louis/657) FY 2015 through February 2015[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$776.3
Number (as of March 17, 2015) of:	
• **Unique Patients**	45,940
• **Outpatient Visits**	297,695
• **Unique Employees**[2]	4,051
Type and Number of Operating Beds:	
• **Hospital**	200
• **CLC**	71
• **MH**	75
Average Daily Census:	
• **Hospital**	126
• **CLC**	42
• **MH**	47
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Belleville/657GA St. Louis/657GB St. Charles County/657GD Washington/657GS
VISN Number	15

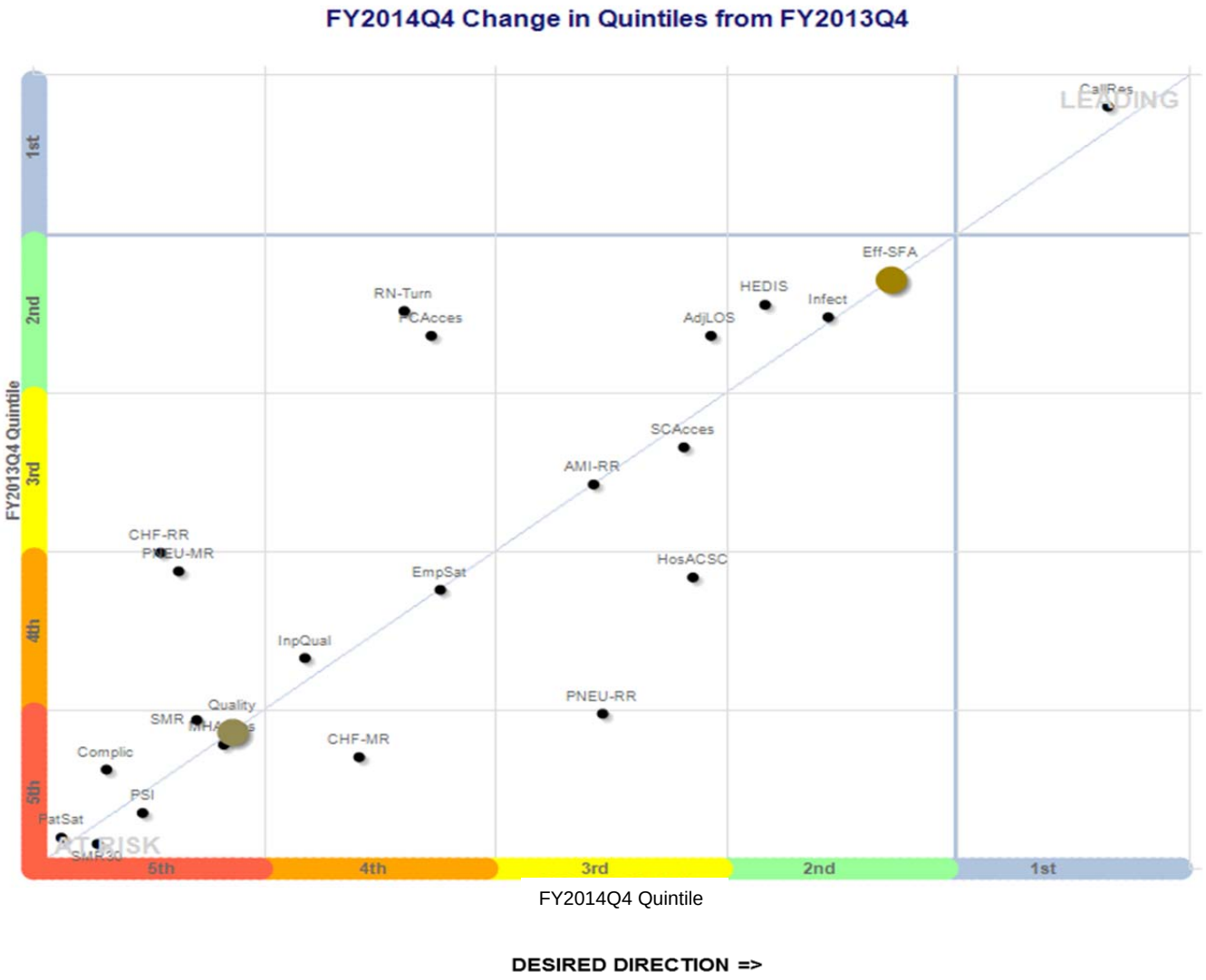
[1] All data is for FY 2015 through February 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 20, 2015

From: Director, VA Heartland Network (10N15)

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

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

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

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

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

(*original signed by:)*
William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 15, 2015

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

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

To: Director, VA Heartland Network (10N15)

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

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

3. If you have any questions, please contact Patty Hendrickson, Director Quality Management.

(*original signed by:)*
Keith Repko
Deputy Medical Center Director
VA St Louis Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director continue to chair Quality Executive Board meetings.

Concur

Target date for completion: June 30, 2015

Facility response: In January 2015, the Interim Medical Center Director began chairing the Quality Executive Board and will continue to do so. The Director, Quality Management will monitor percentage of Quality Executive Board meetings chaired by the Medical Center Director for six month period of January 2015 to June 2015 number of Medical Center Director chair or co-chaired (divided by number of Quality Executive Board meeting multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 2. We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

Concur

Target date for completion: May 1, 2015

Facility response: In October 2014, the facility risk manager implemented a change in Peer Review Committee process to invite providers who receive an initial Level 2 or Level 3 rating to provide input to the Peer Review Committee prior to the final determination. Providers are given the opportunity to provide input via in-person or telephonic presentation to the committee or a written response. The Director, Quality Management will monitor the percentage for the six month period of October 2014 to March 2015 (number of providers with Level 2 or Level 3 initial rating who received notification divided by number of providers with Level 2 or Level 3 initial rating multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Peer Review Committee and Quality Executive Board minutes.

Recommendation 3. We recommended that the Medical Executive Board and the Facility Director consistently review and approve all privilege forms annually and all revised privilege forms and document the review.

Concur

Target date for completion: June 30, 2015

Facility response: The Medical Executive Board and the Facility Director will consistently review and approve all privilege forms annually and upon revision. This review and approval will be documented by signature of the Medical Executive Board minutes or memorandum from Chair Professional Standards Board thru the Medical Executive Board to the Facility Director. The Director, Quality Management will monitor the percentage (number of privilege forms have completed annual review plus the number of revised forms that were reviewed and approved divided by number current privilege forms plus the number of revised multiplied by 100) with a goal of 100% compliance. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 4. We recommended that facility managers ensure that licensed independent practitioners who perform emergency airway management have properly approved/signed privilege forms.

Concur

Target date for completion: June 30, 2015

Facility response: The Chair, Professional Standards Board will ensure that all licensed independent practitioners who perform emergency airway management have properly approved/signed Out of Operating Room Airway Management (OORAM) privilege forms. The Director, Quality Management will monitor the percentage (number of properly approved/signed OORAM privilege forms divided by number OORAM privilege forms multiplied by 100) with a goal of 100% compliance for the period of January 2015 to June 2015. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 5. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: December 31, 2015

Facility response: The Supervisor, Credentialing and Privileging (C&P) will ensure that licensed independent practitioners (LIP) folders do not contain non-allowed information. The Supervisor C&P will provide education to C&P staff on non-allowed information in LIP folders. C&P staff will remove non-allowed information from folders as they process the folders for re-privileging or filing. Director, Quality Management will audit a sample

of 30 LIP folders each month beginning March 2015 to December 2015 for percentage (number of compliant folders divided by the number of folder audited multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 6. We recommended that the facility implement a policy that defines Surgical Work Group membership.

Concur

Target date for completion: June 30, 2015

Facility response: The facility will develop and implement a medical center memorandum that defines the Surgical Work Group membership. Upon approval it will be published via the VA St Louis Health Care System intranet site.

Recommendation 7. We recommended that the Surgical Work Group document its review of National Surgical Office reports and its review of all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: September 30, 2015

Facility response: The Surgical Work Group revised the committee's standard agenda to include routine review of National Surgical Office reports and surgical deaths. Identified problems or opportunities for improvement will be documented in the Surgical Work Group's minutes. Director, Quality Management will audit the Surgical Work Group minutes for compliance with review of National Surgical Office reports, surgical death and documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Surgical Work Group and Quality Executive Board minutes.

Recommendation 8. We recommended that clinicians report all critical incidents through the facility's adverse event reporting process.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Surgical Service will ensure that all critical incidents are reported through the facility's adverse event report process. The Director, Quality Management will monitor compliance (number of critical incidents with an adverse event report submitted divided by the number of critical incidents multiplied by 100) each month beginning April 2015 through September 2015 with a goal of 90%. The results

will be reported and recorded in the Surgical Work Group and Quality Executive Board minutes.

Recommendation 9. We recommended that the facility review the quality of entries in the electronic health record and analyze data at least quarterly.

Concur

Target date for completion: September 30, 2015

Facility response: Chief, Health Information Management and Chair of Medical Records Review Committee will ensure that the Medical Records Review Committee reviews and analyze data on the quality of entries in the electronic health records at least quarterly. The data and analysis will be reported and recorded in the Medical Records Review Committee Minutes. The Director, Quality Management will monitor compliance.

Recommendation 10. We recommended that the facility fully implement the new quality control policy for scanning and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Health Information Management Service will ensure that the new quality control policy for scanning is fully implemented. The Director, Quality Management will monitor the percentage (number of completed reviews of scanned documents for readability and retrievability divided by the number of expected reviews multiplied by 100) scanned document reviews and quality assurance reviews for the months of April 2015 to September 2015 with a goal of 90% compliance. The results will be reported and recorded in the Medical Records Committee minutes and Quality Executive Board minutes.

Recommendation 11. We recommended that Environment of Care Committee minutes include discussion regarding environment of care rounds deficiencies and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chair, Environment of Care Committee will ensure the Safety Officer will report and discuss environment of care round deficiencies at the Environment of Care Committee. Summary of environment of care rounds with any identified problems or opportunities for improvement will be recorded in Environment of Care Committee Minutes. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with environment of care round deficiencies documentation of identified problems or opportunities for improvement each month

beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 12. We recommended that facility managers ensure patient care areas and public restrooms are clean and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Environment Management Service will ensure patient care areas and public restrooms are clean. Monitoring will occur as part of environment of care rounds. The Chair Environment of Care Committee will ensure cleanliness of patient care areas and public bathrooms deficiencies found on environment of care rounds are reported at the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 13. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: September 30, 2015

Facility response: The Nurse Manager had the damaged furniture removed from patient care areas when it was identified during the CAP inspection. The Chair, Environment of Care Committee will ensure damaged furniture deficiencies found on environment of care rounds are reported at the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 14. We recommended that the facility store oxygen tanks in a manner that distinguishes between empty and full tanks and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Safety Officer will ensure the standard oxygen tank storage and signage is present in all locations. The Chair Environment of Care Committee will ensure oxygen tank deficiencies found on environment of care rounds are reported at the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 15. We recommended that facility managers ensure all electrical gang boxes have the appropriate covers installed.

Concur

Target date for completion: September 30, 2015

Facility response: Electrical shop foreman installed covers on identified gang boxes in the Progressive Care Unit on the same day it was identified on the CAP inspection. The Chair, Environment of Care Committee will ensure electrical boxes cover deficiencies found on environment of care rounds are reported at the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 16. We recommended that the facility store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Ward or Clinic managers will ensure that clean and dirty items are stored separately. The Chair, Environment of Care Committee will ensure storage of clean and dirty items deficiencies found on environment of care rounds are reported at

the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 17. We recommended that the facility promptly remove outdated commercial supplies from sterile supply rooms and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief Logistics and ward or clinic manager will ensure that outdated commercial supplies are removed from sterile supplies rooms. The Chair, Environment of Care Committee will ensure outdated supply deficiencies found on environment of care rounds are reported at the Environment of Care Committee. Director, Quality Management will audit the Environment of Care Committee minutes for compliance with reporting environment of care round deficiencies documentation of identified problems or opportunities for improvement each month beginning April 2015 to September 2015 for compliance percentage (number of compliant minutes divided by the number of minutes reviewed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 18. We recommended that the facility promptly remove expired medications from patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief, Pharmacy Service and Ward or Clinic manager will ensure that expired medication is removed from patient care areas. The Chief, Pharmacy Service will ensure pharmacy inspections are completed according to policy for patient care areas. Director, Quality Management will monitor a sample of fifty (50) pharmacy inspections each month April 2015 to September 2015 for percentage (number of completed inspections with documentation of checking for and removal of expired medication divided by the number of inspections audited multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 19. We recommended that the facility label medications in accordance with local policy and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Patient care area mangers will ensure mediations are labeled in accordance with policy. Quality Management staff will inspect fifty (50) medication locations each month for appropriate labeled medications. Director, Quality Management will monitor a sample of fifty (50) pharmacy inspection each month April 2015 to September 2015 for percentage (number of completed inspections with documentation appropriate labeled medications divided by the number of inspections completed multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 20. We recommended that the facility inspect alarm-equipped medical devices according to local policy and the manufacturers' recommendations and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief, Biomedical Engineering will insure alarm-equipped medical devices are inspected according to local policy and the manufacturer's recommendations. The Chair, Environment of Care Committee will ensure the Chief, Biomedical Engineering will report compliance with inspecting alarm-equipped medical devices. Director, Quality Management will monitor alarm-equipment device inspection completion rate beginning April 2015 to September 2015 (number of completed alarm-equipped device inspections divided by the number of expected inspections multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 21. We recommended that the facility document functionality checks of the community living center's elopement prevention system at least every 24 hours and conduct and document annual complete system checks and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief, Facility Engineering will ensure annual complete system check is completed on the community living center elopement prevention system. Associate Chief Nurse Extended Care will ensure functional check is completed at least every 24 hours of the community living center elopement prevention system. Director, Quality Management will monitor completion of the annual completion system check and

compliance with at least every 24 hour functional check of the community living center elopement prevention system (number of completed function check at least every 24 hours divided by the number of expected functional checks multiplied by 100) with a goal of 90%. The results will be reported and recorded in Quality Executive Board minutes.

Recommendation 22. We recommended that the facility inspect and tag critical medical equipment in the community living center and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief, Biomedical engineering will insure medical equipment in the community living center is tagged and inspected according to local policy and the manufacture's recommendations. The Chair, Environment of Care Committee will ensure the Chief, Biomedical Engineering will report compliance with inspecting medical devices. Director, Quality Management will monitor equipment device inspection completion rate beginning April 2015 to September 2015 (number of completed devices inspections divided by the number of expected inspections multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Environment of Care Committee minutes and Quality Executive Board minutes.

Recommendation 23. We recommended that facility managers ensure crash cart logs contain the correct lock numbers and monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Patient care area mangers will ensure crash cart logs contain correct lock numbers. Director, Quality Management will monitor compliance by auditing thirty (30) crash carts logs each month beginning in April 2015 through September 2015 for compliance with recording correct lock number (number of crash carts logs with correct crash cart logs divided by the number of crash cart logs audited multiplied by 100) with a goal of 90%. The results will be reported and recorded in Code K Committee and Quality Executive Committee minutes.

Recommendation 24. We recommended that the facility ensure the look-alike and sound-alike medication list is available for staff reference in all areas.

Concur

Target date for completion: April 30, 2015

Facility response: The facility list of look-alike and sound-alike medication will be available for staff reference through posting on the CPRS tool bar. This will be

communicated to all staff through All-Employee email and inclusion in Pharmacy News Notes.

Recommendation 25. We recommended that the facility ensure the high-alert medication list is available for staff reference.

Concur

Target date for completion: April 30, 2015

Facility response: The facility list of high-alert medication will be available for staff reference through posting on the CPRS tool bar. This will be communicated to all staff through All-Employee email and inclusion in Pharmacy News Notes.

Recommendation 26. We recommended that the facility create/designate a committee to oversee consult management.

Concur

Target date for completion: April 30, 2015

Facility response: The facility established the Consult and Access Committee in November 2014 to oversee consult management. The Consult and Access Committee policy was published in March 2015.

Recommendation 27. We recommended that the Medicine, Mental Health, Surgical, and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: Chief of Staff will ensure that Medicine, Mental Health, Surgical and Extended Care and Rehabilitation Services' Automated Data Processing Applications Coordinators provide training in the use of the computerized consult package to incumbent providers and all new providers as part of orientation. Training will be documented in Talent Management System under a local course number. Service Automated Data Processing Application Coordinator will report training monthly to Consult and Access Committee. Director, Quality Management will audit the Consult and Access Committee minutes for compliance with reporting training each month beginning April 2015 to September 2015 for compliance percentage (number of training reports divided by the number of expected reports multiplied by 100) with a goal of 90%. The results will be reported and recorded Quality Executive Board minutes.

Recommendation 28. We recommended that Medicine, Mental Health, Surgical, and Rehabilitation Services designate an individual to review and manage consults.

Concur

Target date for completion: April 30, 2015

Facility response: Chief of Staff designated an individual to review and manage consults for Medicine, Mental Health, Surgical and Extended Care and Rehabilitation Services.

Recommendation 29. We recommended that requestors consistently select the proper consult title and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The facility clinical application coordinator reviewed all active consult titles to ensure compliance with consult business rules for naming conventions to ensure requestors select the proper consult title. Consults titles were modified to meet business rules. Director, Quality Management will monitor compliance using VSCC Consult Title Needing Attention report which identifies consults not meeting naming convention rules monthly for the months of April 2015 to September 2015 with goal of zero (0) consults on the report or modification of consult title within 5 business days of identification. The results will be reported and recorded in the Consult and Access Committee and Quality Executive Board minutes.

Recommendation 30. We recommended that the facility complete secondary patient safety screenings immediately prior to magnetic resonance imaging and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Diagnostic Imaging will ensure secondary patient safety screen is complete immediately prior to magnetic resonance imaging is completed and documented in the patient records. Director, Quality Management will monitor compliance thru audit of randomly selected patient records each month April 2015 thru September 2015 for the documentation of secondary safety screen (number of patient records with documented secondary safety screen divided by number of records audited multiplied by 100). The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 31. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Diagnostic Imaging will ensure that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan. Director, Quality Management will monitor compliance thru audit of fifty (50) randomly selected patient records each month April 2015 thru September 2015 for the documentation of resolution of magnetic resonance imaging contraindications (number of patient records with documented resolution of magnetic resonance imaging contraindications divided by number of records audited multiplied by 100). The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 32. We recommended that the facility ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Diagnostic Imaging will ensure all designated Level 1 ancillary staff receive annual level-specific magnetic resonance imaging safety training. Designated Learning Officer will ensure monthly training compliance reports are provided to the Chief Diagnostic Imaging for tracking compliance. Director, Quality Management will monitor compliance with completion of training beginning April 2014 thru September 2015 (number of staff with completed training divided by the number of staff assigned training multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 33. We recommended that the facility ensure all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Diagnostic Imaging will ensure all designated Level 2 magnetic resonance imaging personnel receive annual level-specific magnetic resonance imaging safety training. Director, Quality Management will monitor compliance with completion of training beginning April 2014 thru September 2015

(number of staff with completed training divided by the number of staff assigned training multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Quality Executive Board minutes.

Recommendation 34. We recommended that the facility revise the stroke policy to address a stroke team and data gathering for analysis and improvement and that facility managers fully implement the revised policy.

Concur

Target date for completion: April 30, 2015

Facility response: The Stroke Committee Medical Center Memorandum was approved and published February 2015. The policy addresses a stroke team and data gathered for analysis and improvement.

Recommendation 35. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Associate Chief of Staff Medicine Service will ensure that clinicians complete and document National Institutes of Health stroke scale for each patient. Quality Improvement Specialist will audit each patient record for completion of the National Institutes of Health stroke scale. Results will be reported to Stoke Care Committee and Associate Chief of Staff Medicine Service. Director, Quality Management will monitor compliance with completion of National Institute of Health stroke scale training beginning April 2014 thru September 2015 (number of patients with completed National Institute of Health stroke scale completed divided by the number of stroke patients multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Stoke Care Committee and Quality Executive Board minutes.

Recommendation 36. We recommended that the facility collect and report to the Veterans Health Administration the percent of patients with stroke symptoms who had the stroke scale completed and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: September 30, 2015

Facility response: The Chair Stoke Care Committee will ensure that facility data is collected and reported to the committee on the percent of patient with stroke symptoms who had stroke scale completed and percent of patient screened for difficulty

swallowing before oral intake. Analysis, problems identified and opportunities for improvement will be recorded in Stoke Care Committee minutes.

Recommendation 37. We recommended that Radiology Service revise the computed tomography scan, magnetic resonance imaging/magnetic resonance angiograms, and radiology interpretation on-call policy to require a 30-minute reporting time.

Concur

Target date for completion: April 30, 2015

Facility response: The Chief, Radiology Service revised the computed tomography scan, magnetic resonance imaging/magnetic resonance angiograms, and radiology interpretation on-call policy to clearly state a required 30-minute reporting time.

Recommendation 38. We recommended that the facility ensure initial clinician emergency airway management competency assessment includes all required elements and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief Anesthesia Service and Chair Professional Standards Board will ensure that initial clinician emergency airway management competency assessment includes all required elements. The Director, Quality Management will monitor the compliance of complete initial emergency airway management assessment (number of completed initial clinician emergency airway management competency assessment divided by the number of initial assessment reviewed multiplied by 100) with a goal of 100% compliance. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 39. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Anesthesia Service and Chair Professional Standards Board will ensure that clinician reassessment for continued emergency airway management competency is completed at the time of renewal of privileges or scope of practice. The Director, Quality Management will monitor the compliance of continuation of emergency airway management competency (number of completed clinician reassessment emergency airway management competency assessment divided by the number of clinicians reassessment reviewed multiplied by 100) with a goal of

100% compliance. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 40. We recommended that the facility ensure clinician reassessment for continued emergency airway management competency includes completion of all required elements at the time of renewal of privileges or scope of practice and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Anesthesia Service and Chair Professional Standards Board will ensure that clinician reassessment for continued emergency airway management competency includes all required elements at the time of renewal of privileges or scope of practice. The Director, Quality Management will monitor the compliance of continuation of emergency airway management competency includes all elements (number of completed compliant clinician reassessment emergency airway management competency assessment divided by the number of clinicians reassessment reviewed multiplied by 100) with a goal of 100% compliance. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 41. We recommended that the facility ensure that clinicians reassessed for continued emergency airway management have a statement related to emergency airway management included in an approved scope of practice.

Concur

Target date for completion: April 30, 2015

Facility response: Chief, Pulmonary Medicine and Respiratory Therapy Program Manager will ensure that clinicians reassessed for continued emergency airway management have a statement related to emergency airway management included in the approved scope of practice. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 42. We recommended that the facility ensure a clinician with emergency airway management privileges or scope of practice or an anesthesiology staff member is available during all hours the facility provides patient care and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2015

Facility response: The Chief, Pulmonary Medicine and Respiratory Therapy Program Manager will ensure that any clinician with emergency airway management privileges or

scope of practice are available during all hours patient care is provided (24/7). Director, Quality Management will monitor compliance by auditing respiratory therapist emergency airway management schedule for the period of April 2015 to September 2015 (number of shift with clinician with emergency airway management privileges or scope of practice divided by the number of shifts per month multiplied by 100) with a goal of 90%. The results will be reported and recorded in the Medical Executive Board and Quality Executive Board minutes.

Recommendation 43. We recommended that facility managers strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations and in instances of occurrence, initiate root cause analyses.

Concur

Target date for completion: April 30, 2015

Facility response: The actions in response to recommendations 38 through 42 strengthen processes to minimize a repeat occurrence in which non-privileged providers perform intubations. The Chief of Staff will ensure that in each instance of a non-privileged provider performs an intubation a root cause analysis is initiated.

Recommendation 44. We recommended that facility managers ensure that only authorized patients, staff, and visitors access the Domiciliary Residential Rehabilitation Treatment Program.

Concur

Target date for completion: April 30, 2015

Facility response: The Associate Chief of Staff Mental Health ensured that only authorized patients, staff and visitors access Domiciliary Residential Rehabilitation Treatment Program areas by modifying close circuit monitors to continually display the elevator lobby.

Recommendation 45. We recommended that facility managers ensure that the Domiciliary Residential Rehabilitation Treatment Program does not have closed circuit television in treatment areas.

Concur

Target date for completion: April 30, 2015

Facility response: The Associate Chief of Staff Mental Health Service ensured that the closed circuit television was removed from Domiciliary Residential Rehabilitation Treatment Program areas.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Larry Selzler, MSPT, Team Leader Stephanie Hensel, RN, JD Cindy Niemack-Brown, LICSW, LIMHP Sherrian Pater, RN James Seitz, RN, MBA Laura Snow, LCSW, MHCL Laura Tovar, LICSW Julie Watrous, RN, MS
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Patrick Smith, M. Stat Jarvis Yu, MS

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Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
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- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

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

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

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

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

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

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

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

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