



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Hemodialysis Nursing Care Issues
at the John Cochran Division
St. Louis VA Medical Center
St. Louis, Missouri**

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding nursing care issues in the hemodialysis (HD) unit of the John Cochran Division of the St. Louis VA Medical Center (STLVAMC), St. Louis, Missouri. A complainant alleged that a licensed practical nurse (LPN) did not provide appropriate care to two HD patients, resulting in their need for emergency care. The complainant further alleged that the HD unit had nursing leadership issues that affected patient care.

We substantiated that the LPN did not recognize and report changes in the condition of a patient who was somnolent and unresponsive at the end of his HD treatment. That patient required emergency medical treatment and died the next day. We did not substantiate that the LPN provided less than standard care for the second patient and continued HD treatment despite the patient's report of chest pain. The patient had a history of chest pain for several days, and a physician had cleared the patient for HD, attributing the pain as musculoskeletal and not cardiac. The LPN reported clinical changes to the charge registered nurse (RN) who assessed the patient, discontinued HD, and called the rapid response team to evaluate the patient.

We did substantiate a lack of effective nursing leadership in the HD unit. Staff competencies were not completed, RN and LPN roles were not delineated, charge nurse responsibilities were not defined, and there was no policy for reporting events to the charge RN or physician. HD staff perceived that they suffered retaliation when they reported complaints against the LPN. HD nursing staff perceived changes in scope of LPN practice as punitive for all staff rather than taking disciplinary action for the one individual. However, based on state nursing regulations and local policy, we concurred that LPNs cannot perform independent initial nursing assessments.

STLVAMC leaders became aware of HD concerns when they received a request for review and an action report from The Joint Commission. Although an action report was submitted, a root cause analysis (RCA) was not conducted to determine potential systems issues.

We made six recommendations related to improving HD nursing assessments, delineating scopes of practice, developing unit specific competencies that include specific HD elements, measuring nursing quality of care, performing an evaluation of staffing in the HD, and complying with Veterans Health Administration requirements for conducting an RCA. The Acting VISN Director and STLVAMC Director concurred with the inspection results and recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Hemodialysis Nursing Care Issues at the John Cochran Division of the St. Louis VA Medical Center, St. Louis, MO

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding the provision of nursing care in the hemodialysis (HD) unit of the John Cochran Division of the St. Louis VA Medical Center (STLVAMC), St. Louis, MO. Specifically, a complainant alleged that a licensed practical nurse (LPN) did not provide appropriate care to two HD patients, resulting in their subsequent need for emergency care, and that the HD unit had nursing leadership issues that affected patient care.

Background

Allegations

A complainant alleged the following regarding an LPN and nursing leadership in the STLVAMC HD unit:

- The LPN did not recognize and report changes in a patient's condition during HD treatment, necessitating emergency care for the patient. The patient was admitted to the intensive care unit (ICU) and died the next day.
- The LPN started a patient on HD, despite the patient experiencing chest pain and refused to discontinue HD treatment when the pain became worse. That patient subsequently required emergent treatment.
- The LPN did not perform proper cultures on HD machines.
- Despite voicing concerns to the HD nurse manager, due to favoritism, no disciplinary action was taken against the LPN.

- The HD unit did not have an effective nurse manager.
- Nursing scope of practice changes put in place were unfairly affecting all HD unit nursing staff.

STLVAMC

STLVAMC is a two-division tertiary care facility in Veterans Integrated Service Network (VISN) 15. The John Cochran Division has 136 acute care beds and is located in the city of St. Louis. It provides acute medical and surgical services, as well as a wide range of specialty care. The Jefferson Barracks Division of STLVAMC is located in south St. Louis County. This Division provides primary care and has 102 acute beds, 50 domiciliary beds, and 71 Community Living Center beds. STLVAMC serves veterans and their families in east central Missouri and southwestern Illinois.

Dialysis is required when the kidneys no longer remove enough waste and fluid from the blood to maintain fluid and electrolyte balance and rid the body of harmful toxins. In HD, a machine with a special filter “cleans” the blood. HD may commonly cause side effects such as cramps, headaches, nausea, or dizziness. When such symptoms occur, clinical staff have several options (such as reducing speed of dialysis, administering medications) available to decrease side effects. Careful monitoring allows staff to administer timely corrective actions.

The STLVAMC HD unit is located at the John Cochran Division. It has 12 beds, serving 38 chronic renal failure patients Monday–Saturday. Chronic patients are dialyzed three times a week. In addition, there are acute renal failure patients who require dialysis as inpatients.

Each HD treatment lasts approximately 4 hours. Patients sit in recliners and may have privacy curtains pulled to separate them from other patients during their treatments. The patients often watch television, sleep, or read during treatments. The HD unit can dialyze up to 24 patients a day. As patients are dialyzed several times a week, HD staff know them well.

STLVAMC HD patients are seen once a month by their nephrologist (kidney specialist) who monitors their physical condition and writes orders for HD treatments. A physician, medical resident, and physician’s assistant are available during HD unit hours for urgent needs or questions. The HD unit is staffed with seven registered nurses (RNs) and eight LPNs who work full-time. There are also two RNs assigned to the intravenous (IV) therapy team who work 50 percent of their time in the HD unit. The nurses (RN/LPN mix) cover overlapping 8-hour shifts, starting at 6 a.m. and ending at 6:30 p.m., with a minimum of six nurses on duty during dialysis treatments.

Scope and Methodology

We conducted a site visit May 23–26, 2011. We interviewed HD staff and the nurse manager, physicians, the patient safety coordinator, infection control staff, STLVAMC managers, and quality management (QM) staff. We reviewed Veterans Health Administration (VHA) and STLVAMC policies, patient medical records, staff competency assessments and training records, QM and safety documents, The Joint Commission (TJC) requirements, and Missouri nursing regulations.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Case Reviews

Patient 1

The patient was a 57-year-old male with end stage renal disease due to hypertension and diabetes. He had coronary artery disease, congestive heart failure, seizure disorder, and a renal mass that urologists were monitoring. He had been on HD since 2001. The patient received 24-hour care in a community nursing home and emergency medical staff (EMS) transported him to the facility via ambulance three times a week for his HD.

In early December 2010 (Day 1), at 12:17 p.m., the subject LPN started the patient on HD. She documented the patient’s mental status as “alert, oriented” in her initial assessment and that he was able to verify his full name and social security number. The LPN documented in the next progress note at 5:38 p.m. that the patient’s treatment was completed and “pt. [patient] arrived to tx. [treatment] sleeping and slept throughout entire tx.” She documented mental status as “slept” and notes that a call was made to the nursing home to give report and to determine if the patient had been given medication to make him sleep. The LPN noted that the nursing home nurse stated the patient had been “acting like that out there all day” and did not know of any medications given that would cause him to be this sleepy.

The same day, at 5:51p.m., an emergency department (ED) physician documented that EMS brought the patient to the ED “because they felt uncomfortable bringing him back to his nursing home after his hemodialysis session today. The patient was unresponsive on presentation to the ED.” The patient had a pulse rate of 95 and pulse oximetry of 80–88 percent (normal 97–100) on 100 percent oxygen delivery. The physician admitted the patient to ICU at 7:17 p.m. and the ICU nurse documented the patient was unresponsive.

At approximately 10:00 p.m., the patient's pulse rate dropped to the 20s and then ceased. Staff called an emergency code and started cardiopulmonary resuscitation (CPR). Because the patient was not breathing spontaneously, he was intubated and placed on mechanical ventilation. Based on laboratory test results, physicians determined the patient was in septic shock and started antibiotics and other medications to treat his condition.

The patient had multiple cardiac arrests and staff performed CPR each time. After discussion with his family on Day 2, the attending physician noted in the chart that the patient was to have no further CPR performed. The patient experienced another cardiac arrest and died at 2:00 p.m.

Because the patient died within 24 hours of hospital admission, the physician reported the death to the coroner for autopsy. The physician reported initial autopsy results to the family as showing hemorrhagic pericarditis, a condition in which the patient has inflammation in the tissue covering the heart and is associated with bleeding around the heart. This condition is associated with renal disease, especially renal failure.

Patient 2

The patient is a 56-year-old male with a history of hypertension, end-stage renal disease, polysubstance abuse, chronic pancreatitis, left ventricular heart dysfunction, and anemia. The patient received HD three times a week in the private sector and received his primary care at STLVAMC.

The patient collapsed at his home in late December 2010. EMS was called and performed CPR on the patient, who was without a spontaneous pulse for approximately 15 minutes. EMS intubated him during CPR and transported him to a private hospital. He remained intubated and was initially placed on mechanical ventilation until his condition improved. He reported he thought he had overdosed on cocaine, stating "my heart stopped." His urine drug screen was positive for cocaine. Physicians treated him with antibiotics for pneumonia and discharged him in early January 2011, with instructions to follow up with his regular medical care providers at the STLVAMC.

The patient came to his STLVAMC primary care clinic for a scheduled appointment 2 days later to follow up on his hospitalization and to report he had experienced chest pain for several days. The patient reported his chest pain began after his recent hospitalization and improved when he coughed. He reported coughing up mucous and occasional blood in his sputum. His primary care provider prescribed nitrostat for chest pain and sent him to the ED for further evaluation.

The patient denied any cocaine use since his discharge from the private hospital. The ED physician admitted the patient to telemetry to monitor his cardiac status and to rule out a

heart attack. His laboratory tests and electrocardiogram were negative for a heart attack. Physicians attributed his chest pain as musculoskeletal from the chest compressions and resulting rib fractures that occurred from the CPR performed in the private sector.

That same day, (Day 1), a nephrologist evaluated the patient's renal status and determined that he could be dialyzed the next day.

On Day 2, nursing progress notes document that the patient had not complained of chest pain and his vital signs remained stable. He was transported from telemetry to the HD unit for his dialysis treatment. Physicians planned to discharge him the next day.

The subject LPN started his HD treatment at 8:40 a.m. The LPN noted the patient's blood pressure was 147/90, his pulse was 78, and his respirations were 16 with decreased breath sounds in both lungs. A nephrologist evaluated the patient during his treatment and determined that the patient could have his supplemental nasal oxygen stopped because the patient did not want it and his oxygen saturation was 98 percent on room air. The patient complained to the nephrologist that his chest was hurting and the nephrologist ordered oral pain medication that the LPN gave the patient.

At approximately 11:15 a.m., the patient became agitated and asked the LPN to take him off dialysis. He complained of his chest hurting. The LPN documented that the charge nurse was aware of the situation and had evaluated the patient. The charge nurse noted that the patient's oxygen saturation rate had decreased from 98 percent to 88 percent. At that time, she paged the rapid response team and instructed the LPN to stop the HD treatment.

The patient quickly became hypotensive with a blood pressure drop from 160/80 to 79/40. He lost consciousness, stopped breathing, and his pulse rate dropped to 40–50 beats per minute. The physician responding to the rapid response page intubated the patient and transferred him to the ICU where respiratory therapists placed him on mechanical ventilation.

Physicians were unable to determine the cause of his respiratory arrest, although several serious causes were ruled out. Computed tomography scans of the chest and head were performed to evaluate the possibility of a pulmonary embolism and acute processes in the brain. Chest x-rays showed no evidence of infection or effusion. The patient's condition slowly improved and he was extubated on Day 6. On Day 8, the patient was transferred from the ICU to a regular unit. The patient received HD treatments during this time and tolerated them without problems.

Physicians had scheduled the patient for discharge on Day 14 but he became anxious and short of breath with wheezing. Respiratory therapy provided a breathing treatment, and his condition improved. He was discharged to home on Day 15.

Inspection Results

Issue 1: Quality of LPN Nursing Care

We substantiated that the LPN did not recognize and report changes in the condition of Patient 1 during HD on Day 1.

The LPN assessed the patient prior to initiating HD and at the end of HD, but there was no assessment documented during the procedure. Her initial assessment noted the patient was alert; however, other nurses in the unit reported that they remembered the patient was sleeping during the entire treatment. The LPN did not report any concerns to the charge nurse or the physician, and only acted on a concern about his mental status when EMS mentioned it at the time of discharge transport. During HD, the patient's recorded blood pressure decreased from 170/101 to 123/87 in 15 minutes without any nursing actions documented.

There was minimal documentation of nursing care/assessment during the patient's HD treatment. This patient was well known to the HD staff since he had been coming three times a week for 10 years, and the LPN presumably should have been able to identify the difference in the patient's mental status as compared to prior treatments. The LPN failed to complete the assessments that are routine practice for HD. Some HD nursing staff recalled the incident clearly and reported that the privacy curtains were drawn around the patient during the entire treatment so they were unable to observe that he was not responsive. Progress notes from nurses administering other HD treatments to this patient on prior occasions indicated more detailed assessments, including a pre, mid-cycle, and post procedure assessment. During a HD treatment in mid-November, the patient had a drop in blood pressure that required nursing interventions to correct the situation.

We did not substantiate the LPN provided less than standard care for Patient 2. The patient had been complaining of chest pain since the time of his admission but physicians had evaluated him and determined the pain was related to musculoskeletal pain from his CPR. They cleared him for HD. The LPN documented that the charge nurse was aware of the chest pain and a physician evaluated the patient during HD. The patient's blood pressure, pulse, and respirations were stable. Three hours into his HD treatment, the patient became anxious, complained of chest pain, and shortness of breath. The LPN reported this to the charge nurse who assessed the patient, discontinued HD, and paged the rapid response team to evaluate the patient.

Issue 2: Improper Culturing of Hemodialysis Machines

We did not substantiate the allegation that the subject LPN did not perform proper cultures on HD machines. We found no evidence to indicate that the subject LPN was wiping HD machines with bleach prior to obtaining cultures.

According to policy, the HD machines are to be cultured every 2 weeks to ensure the machines do not have bacteria that could be transmitted to patients. If results are positive, the machines are removed from service until decontaminated. The HD nurse manager reports the culture results monthly to the STLVAMC infection control (IC) oversight committee. We interviewed the IC nurses and reviewed the IC committee minutes. Culture results had been reported as scheduled, and no one was aware of any patient who had contracted an infection due to bacterial growth in machines.

Issue 3: Staff Favoritism and Lack of Disciplinary Action

We did not substantiate the allegation that the HD nurse manager favored the subject LPN.

The nurse manager told us that she and the LPN had known each other and worked together for over 20 years and had a close, personal friendship. We were told repeatedly that the HD nurse manager favored the LPN in question. Examples of areas where favoritism was alleged include; assigning daily work duties, scheduling of weekends and days off, dealing with patient care concerns raised by staff, and dealing with concerns raised over culturing dialysis machines. Some staff reported they had suffered retaliation when complaints were reported against the LPN. An example of perceived retaliation was the scheduling of one staff nurse to work six weekends in a row. Nevertheless, we were unable to prove or disprove the allegations in part because they were subjective in nature.

Issue 4: Lack of Effective HD Nursing Leadership

We substantiated there was a lack of effective nursing leadership in the HD unit. The nurse manager was in the process of reassignment when we were onsite.

The unit was lacking a strong leadership presence in the nurse manager and charge nurse roles. It was difficult to differentiate between the role of the RNs and the LPNs. There was no defined responsibility for the charge nurse and no policy for reporting events to the charge nurse or a physician. The nurse manager had not completed unit specific competency assessments, and scopes of practice were not unit specific. This lack of clear role responsibilities and expectations, along with missing competency evaluations led to confusion and disorder in the unit. Since the HD unit is an area with highly complex patients undergoing critical therapy, staff need to clearly understand their responsibilities and act on them in a consistent manner. This is of particular importance in the area of patient assessments, specifically what is included in an assessment of HD patients, who is responsible for doing the assessment, when this is required, and what is considered abnormal and needs to be reported to the charge nurse or physician. Currently existing confusion in this area creates a risk that staff may not assess critical patient elements and that changes in a patient's condition could be missed.

The nurse manager was unable to determine if staff was following expectations since there were no quality reviews in the unit. Without data on the quality of nursing practice in HD, management does not know if changes have been effective and if staff is providing the quality care that is expected. The nurse manager had not completed any competency assessments for 2010 and the only documents available for 2011 were training records for use of HD equipment.

We determined that lack of leadership resulted in complaints related to staffing the unit. The unit has an equal mix of RNs and LPNs and they performed the same patient assessments and HD treatments. The nurse manager also used IV team nurses to work on the HD unit. These nurses filled in when HD staff called in sick but the nurse manager also scheduled them to work on a routine 2-week assignment every month. The nurse manager agreed that there were frequent call-ins, but reported she had not had time to go through the report about the use of sick leave that was on her desk. Nursing leadership needs to assure staff that issues are being reviewed and actions are taken, while protecting the privacy of the individual.

Issue 5: Change in Nursing Scope of Practice

We did not substantiate that nursing practice changes unfairly affected HD nursing staff. Nursing administration had proposed changes in nursing practice as a result of reviews regarding quality of nursing care in the HD unit.

The HD nurse manager developed a list of specific responsibilities for the RN and the charge nurses, which was seen as a change in their practice. The list included such things as a huddle to communicate patient status during the middle of HD and the documentation/co-signing of LPN assessments by an RN. The LPNs in particular were confused about the changes, believing that one LPN's actions resulted in unfair changes for all of them and downgraded their practice.

VHA requires that assignments of LPNs at all grade levels be based upon the validation of competence to perform clinical procedures and certification of these competencies.¹ VHA GS-6 level LPN qualification standards require the LPN to be able to carry out patient care for a variety of patients and to observe, identify, and respond to those patients' care needs.² They are expected to have the knowledge and skill to perform complex diagnostic tests and specialized practices and procedures. While completed work should only need a general review by a RN or physician for appropriateness and conformity with policies, in accordance with state statutes, practical nursing care shall be given under the guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a RN. LPNs are not

¹ VHA "Handbook 5005/3, *Staffing*, April 10, 2003.

² VHA Handbook 5005/3 Part II, *Staffing*, Appendix G13. *Licensed Practical or Vocational Nurse Qualification Standard*, April 10, 2003.

authorized to perform independent nursing care and must know under whose specific direction they are working at any given time.³

Nursing leadership shared with HD staff that LPNs could not perform independent initial patient assessments. HD unit LPNs had not been held to this standard, so they appeared to perceive several changes made as punitive actions when this was not the intention. The new practice is that the RNs will conduct a pre-HD assessment and a pre-discharge assessment on all patients. Both RNs and LPNs were unsure of their roles and responsibilities at the time of our inspection because the change had not been implemented.

Conclusions

We substantiated that the subject LPN did not recognize and report changes in the condition of Patient 1 during HD on Day 1. This patient was well known to the HD staff and the subject LPN presumably should have been able to identify a decline in the patient's mental status. We did not substantiate the LPN provided less than standard care for Patient 2.

We did not substantiate the allegation that the subject LPN did not perform proper cultures on HD machines. We found no evidence to indicate that the subject LPN was wiping HD machines with bleach prior to obtaining cultures. We did not substantiate the allegation that the HD nurse manager favored the subject LPN.

We concluded that the HD unit had multiple problems that required improvement. The unit was lacking a strong leadership presence in the nurse manager and charge nurse roles. It was difficult to differentiate between the role of the RNs and the LPNs. There was no defined responsibility for the charge nurse and no policy for reporting events to the charge nurse or a physician.

We did not substantiate that nursing practice changes unfairly affected HD nursing staff. Nursing administration had proposed changes in nursing practice as a result of reviews regarding quality of nursing care in the HD unit.

The Patient Safety Manager (PSM) did not assign a Safety Assessment Code score for Patient 1's adverse event; therefore, the PSM did not use the scoring matrix to determine the need for a root cause analysis (RCA).⁴ Although STLVAMC managers submitted an action report to The Joint Commission, a RCA was not conducted according to VHA requirements to determine potential systems issues.

³ State of Missouri Board of Nursing, *LPN Scope of Practice*, Nurse Practice Act 1999.

⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook, Appendix B*, March 4, 2011.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensures that the expectations for what constitutes a complete HD assessment and who can perform the assessment be identified and provided to HD nursing staff.

Recommendation 2. We recommended that the Medical Center Director ensures that the scope of practice for the HD, RN, and LPN are clearly delineated.

Recommendation 3. We recommended that the Medical Center Director ensure that HD unit specific competencies that include specific HD elements needed for the delivery of quality care are developed and implemented.

Recommendation 4. We recommended that the Medical Center Director ensure that HD nursing staff is currently competent in unit specific responsibilities and that an ongoing process to measure the quality of nursing care be developed and implemented.

Recommendation 5. We recommended that the Medical Center Director ensure that Human Resources perform an evaluation of staffing in HD to evaluate the accuracy of job descriptions, the use of leave, and potential scheduling issues.

Recommendation 6. We recommended that the Medical Center Director ensure that the PSM follows VHA requirements for conducting RCAs.

Comments

The Acting VISN Director and STLVAMC Director concurred with the inspection results and recommendations (see Appendixes A and B, pages 11–15, for the full text of their comments and actions). We will request documentation of actions to ensure completion.



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

Acting VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 8, 2012

From: Acting Director, VA Heartland Network (10N15)

Subject: **Healthcare Inspection – Hemodialysis Nursing Care Issues at the John Cochran Division of the St. Louis VAMC, St. Louis, Missouri**

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

Thru: Director, VHA Management Review Service (10A4A4)

1. Attached, please find the St. Louis VA Medical Center Healthcare Inspection – Hemodialysis Nursing Care Issues response.
2. If you have any questions regarding the information provided, please contact Patty Hendrickson, Director of Performance Improvement. Ms. Hendrickson can be reached at (314) 652-4100, ext. 55590 or 314-606-0108.
3. I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused towards continuous performance improvement.



William P. Patterson, MD, MSS
Acting Director, VA Heartland Network (10N15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 8, 2012

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

Subject: **Healthcare Inspection – Hemodialysis Nursing Care
Issues at the John Cochran Division of the St. Louis
VAMC, St. Louis, Missouri**

To: Acting Director, VA Heartland Network (10N15)

1. I have reviewed and concur with the findings and recommendations in the Healthcare Inspection – Quality of Care Issue in Dialysis, John Cochran Division of the St Louis VA Medical Center, St Louis Missouri.
2. Appropriate actions were taken at the time of the events described in the report. The actions have been completed as detailed in the attached response.

(original signed by:)
RimaAnn O. Nelson RN MPH/HSA
Director, STLVAMC (657/00)

Recommendation 3. We recommended that the Medical Center Director ensure that HD unit specific competencies that include specific HD elements needed for the delivery of quality care are developed and implemented.

Concur

Target Completion Date: June 30, 2011

Facility's Response:

Unit and position specific competencies were developed and implemented for 100% of nursing staff in HD. Competency Assessment included documentation of self assessment, validation method, verifier and date of assessment. Competency folder audit by Quality Management staff verified the completion of unit and position specific competency.

Status: Completed

Recommendation 4. We recommended that the Medical Center Director ensure that HD nursing staff is currently competent in unit specific responsibilities and that an ongoing process to measure the quality of nursing care be developed and implemented.

Concur

Target Completion Date: December 30, 2011

Facility's Response:

Quality Management and Designated Learning Officer staff completed competency folder audit to ensure that unit specific competency. Results showed 100% of staff had documentation competency in unit specific items. HD personnel were retrained on Medical and Surgical Assessment via an on-line course presentation (100% successfully completed). Measures of on-going quality of nursing care include:

- Compliance with completion of assessments according to policy through medical record review Performance is at a mean of 97%.
- Compliance with documentation of RN oversight of LPN through medical record review. Performance is 100%.
- Compliance with notification of nephrologists for changes in patient condition or assessment. Performance is at a mean of 95%.
- Compliance with pre and post treatment hand off communication between HD and inpatient ward or transferring facility. Performance is at a mean of 96%.

- Mid-cycle dialysis huddle with treating nurse was implemented. Performance is at a mean of 92%.

Status: Completed

Recommendation 5. We recommended that the Medical Center Director ensure that Human Resources perform an evaluation of staffing in HD to evaluate the accuracy of job descriptions, the use of leave, and potential scheduling issues.

Concur **Target Completion Date:** September 30, 2011

Facility's Response:

The Assistant Director of Patient Care Services and Associate Chief of Nursing Education completed a review of staffing, functional statements, leave usage, and scheduling practices. Assistant Director of Patient Care Services appointed an Acting Nurse Manager who implemented revised scheduling practices, competency assessments, and functional statements. The Associate Chief of Nursing Education requested and was approved for additional RN full time employee equivalents and the conversion of one LPN position to a RN position. This changed the ratio of LPN to RN from 50% LPN and 50% RN to 30% LPN and 70% RN.

Status: Completed.

Recommendation 6. We recommended that the Medical Center Director ensure that the patient safety coordinator follows VHA requirements for conducting RCAs.

Concur **Target Completion Date:** May 31, 2011

Facility's Response:

An RCA on the patient event was completed and submitted to Joint Commission as required by Accreditation Participation Standards. A copy of this RCA was provided to the OIG staff. The Medical Center Director instructed the PSM to submit TJC RCA in a manner and format that follows VHA requirements.

Status: Completed

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Dorothy Duncan, RN, MHA Regional Director Kansas City, Project Leader Jennifer Kubiak, RN, MPH Team Leader Robert Yang, MD Medical Consultant Jennifer Whitehead, Program Support Assistant

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