Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, Florida

Report No. 02-03094-101 **May 22, 2003**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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

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Contents

Executive Summary

Introduction

During the week of September 16-20, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James A. Haley VA Medical Center, Tampa, Florida. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 60 employees.

Results of Review

Medical center patient care and QM activities reviewed were generally operating satisfactorily. The Homemaker/Home Health Aide and Mental Health and Behavioral Sciences Programs were also operating satisfactorily; controlled substances were being properly inspected and inventoried; and the medical center was managing its patient waiting list. Financial and administrative activities reviewed generally needed some improvement. To improve operations, the Medical Center Director needed to:

- Improve the safety and cleanliness of the medical center.
- Improve Automated Information Systems (AIS) security.
- Strengthen controls over time and attendance of part-time physicians.
- Ensure that charges for transcription services are properly verified.
- Improve the physical security of the outpatient pharmacy.

We also made suggestions regarding the Government Purchase Card Program, and QM follow up of root cause analyses.

VISN Director Comments

The VISN and Medical Center Directors agreed with the findings, recommendations, and suggestions and provided acceptable improvement plans. (See Appendix A, page 11, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. The James A. Haley VA Medical Center, Tampa, Florida is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at the Orlando VA Health Care Center, the New Port Richey and the Brevard Outpatient Clinics, and at five community-based outpatient clinics located in central Florida. The medical center is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of about 438,000 in a primary service area that includes 8 counties in Central Florida.

Programs. The medical center provides medical, surgical, mental health, geriatric, and advanced rehabilitation services. The medical center has 301 hospital operating beds, 298 nursing home operating beds (180 at the medical center and 118 at the Orlando VA Health Care Center) and 18 domiciliary beds. The medical center has several referral and treatment programs, including spinal cord injury, radiation therapy, cardio-vascular surgery, rehabilitation, traumatic brain injury, women's health, endocrinology, and home health care. The medical center also has sharing agreements with nine military bases, and nine sharing agreements with the State of Florida for clinical and nursing home services.

Affiliations and Research. The medical center is affiliated with the University of South Florida Schools of Medicine and Nursing, and supports 138 medical resident positions in 20 training programs. During fiscal year (FY) 2002, the medical center had 167 research projects with a budget of about $3.3 million. Important research areas include: cardiology, endocrinology, oncology, hematology, surgery, infectious diseases, neurology, mental health and behavioral sciences, health services research and development (outcomes), and rehabilitation.

Resources. In FY 2001, medical care expenditures totaled over $321 million. The FY 2002 medical care budget was over $345 million. FY 2001 staffing totaled 3,330 full-time equivalent employees, including 241 physicians and 1,009 nursing employees.

Workload. In FY 2001, the medical center treated 102,306 unique patients. The medical center provided 77,332 inpatient days of care in the hospital and 87,473 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload included 9,276 discharges, and the average daily census for the hospital was 212 and 240 for the two NHCUs. The outpatient care workload was 972,196 visits.

Objectives and Scope of CAP Review

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following programs and activities:

Automated Information Systems Security	Part-Time Physician Time and Attendance
Controlled Substances Accountability	Pharmacy Security
Environment of Care	Quality Management
Government Purchase Card Program	Contracts
Homemaker/Home Health Aide Program	Waiting List and Patient Waiting Times
Mental Health and Behavioral Sciences	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. The survey results were provided to medical center management.

During the review, we also presented four fraud and integrity awareness briefings for medical center employees. A total of 60 out of over 3,000 employees attended these briefings, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Our review covered medical center operations from October 1, 1998, through September 30, 2002, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN 8 and/or medical center management until corrective actions are completed.

Results of Review

Organizational Strengths

Patient care administration and QM activities reviewed were generally operating satisfactorily.

Nursing Care Was Nationally Recognized for Excellence. In 2001, the medical center received the Magnet Recognition Program Award for demonstrating sustained nursing care excellence. The Magnet Recognition Program, administered by the American Nurses Credentialing Center, monitors healthcare organization compliance with program standards and recognizes organizations dedicated to providing excellent nursing care services. The medical center is the only VA facility that has received this recognition.

Opportunities for Improvement

Environment of Care – Safety and Cleanliness Need Improvement

Conditions Needing Improvement. Safety problems were found with hazardous cleaning chemicals security, fire extinguishers, medications, mattress covers, and crash carts. Several areas of the medical center were not clean, including some patient care areas, the Food and Nutrition Service (F&NS) kitchen, and the Veterans Canteen Service (VCS) dining room and food preparation areas. The conditions identified were discussed with the supervisors of the areas inspected and with the Medical Center Director. The Director agreed to take necessary corrective action**.**

To assess the safety and cleanliness of the medical center, we inspected medical Ward 7N, surgical Wards 4S and 4W, psychiatric Ward 2BSW, the Surgical Intensive Care Unit (SICU), the Cardiac Care Unit (CCU), the Medical Intensive Care Unit (MICU), the Post-Anesthesia Care Unit (PACU), the Hemodialysis Unit (HDU), NHCUs A and D, Spinal Cord Injury Unit (SCIU) D, the Women's Center, three primary care clinics (Alpha, Bravo, and Charlie), the Emergency Room (ER), two outpatient clinics (Dental and Urology), and ancillary and support areas.

Safety Issues Needed to Be Addressed. The following safety deficiencies were identified.

- Over a 3-day period, we observed 21 housekeeping carts left unattended. Door locks on housekeeping closets containing hazardous cleaning chemicals and housekeeping carts were unlocked and the door locks to SCIU D were taped open.
- The ER's medical supply room door was propped open.
- The fire extinguishers in the HDU and F&NS had not been inspected in 2 months. Access to fire extinguishers in fire apparatus closets was obstructed by equipment (F&NS, ER, and the HDU).

- Batteries were inappropriately stored in medication refrigerators throughout the facility.
- Medication refrigerators in the Alpha and Bravo Clinics and medication cabinets in the PACU were unlocked.
- The medication refrigerator in the Bravo Clinic was unplugged and the medication containers were wet. The medication refrigerator in NHCU A was set on defrost, was full of water, and the medications were warm.
- Water was dripping from the ceiling onto the Pyxis® medication distribution machine in the SICU.
- All three mattresses inspected on recovery room stretchers in the PACU had multiple splits, tears, and holes in the rubberized surface.
- Crash carts were not properly inspected in the ER, Ward 4W, SCIU D, and Ward 2BSW as required.
- Defibrillators were not checked in the ER, Ward 7N, and Ward 4W. The defibrillator on Ward 4W was not with the crash cart, but locked in a closet down the hall.
- The dental clinic, where patients were regularly sedated for oral surgery, did not have a defibrillator, as required by the VHA standard of care for sedated patients.
- In May 2002, the Prevention of Violence in the Workplace Subcommittee was tasked with prioritizing panic button requests to improve the safety and security of patients and employees. However, there was no evidence that the Subcommittee had addressed this issue.

Some Patient Care Areas Needed Cleaning. Patient care areas reviewed were generally clean. However, medical Ward 7N and the HDU were not clean, and most nourishment refrigerators inspected needed attention.

- Ward 7N. Patient rooms and bathrooms were not clean. Equipment bases and pedestals in unoccupied rooms were often dirty and dust laden, and bathroom floor tiles and grout were discolored. Several patient bathrooms smelled of urine. Windowpanes and flat surfaces were dusty. The hall handrail was broken, several ceiling tiles were water stained, the ice machine leaked, and paint was peeling from several doorframes. Some patient room walls had holes and one patient bathroom was missing the laminate from the countertop.
- The HDU. The supply room floor was covered with debris and dust. Office furniture in the patient care area was dirty and broken. Debris was visible in the ceiling lights and we observed dirty streaks on the walls leading to the skylight. Patient chairs and/or dialysis machines blocked hand-washing sinks. Patient gowns and blankets were stored on uncovered carts in the patient waiting room. The patients' training room was crowded with extra dialysis machines and equipment. Floors had an accumulation of dirt around furniture and wall edges. A linen bag in the visitors' restroom contained a mixture of linens, garbage, disposable utensils, and reusable equipment.
- Nourishment Refrigerators. There were expired nourishments, opened cartons of milk, and some employee food in patient nourishment refrigerators on Ward 7N, Ward 4W, SICU, CCU, and NHCUs A and D.

The F&NS Kitchen Needed Deep Cleaning.

- Edges of all floors had a build up of dirt that extended 4 to 6 inches from the walls and grout was stained throughout the area, and wall tiles were broken and chipped.
- Ceiling tiles and grids in several areas needed replacement. Ceiling tiles around vents had a thick accumulation of black dust, ceiling tiles in the dishwashing room had water damage, and a metal ceiling panel in the solvent room was rusted.

Some VCS Areas Needed Cleaning. The overall appearance of the VCS canteen was acceptable; however, several areas inspected were not clean.

- Ceiling tile grids were rusted and ceiling tiles were soiled or water stained. Some ceiling tiles in the wash and food preparation areas were bulging from moisture.
- Floor edges in both the kitchen and dining room needed deep cleaning. Dirty wax runoff from a main hallway waxing extended into the canteen office hall.

Overall, the conditions identified during our inspection were consistent with responses to questionnaires sent to medical center employees. Approximately 45 percent of employees responding believed that housekeeping support was not adequate to maintain patient safety and general cleanliness, and 33 percent of employees responding believed that work orders to correct safety and cleanliness issues were not promptly completed. During the inspections, supervisors in three areas pointed out incomplete work orders that would have addressed some of the conditions found.

Recommended Improvement Action 1. The VISN Director should ensure that the Medical Center Director takes action to ensure:

a. Patient care and common areas are routinely inspected and kept in a safe and clean condition.
b. Hazardous cleaning supplies are secured.
c. Compliance with fire and safety codes regarding fire apparatus.
d. Compliance with VHA regulations concerning security and storage of medications.
e. Damaged recovery room stretcher mattresses are replaced.
f. Crash carts and defibrillators are properly checked and documented.
g. A defibrillator is located in the dental clinic.
h. The Prevention of Violence in the Workplace Subcommittee addresses the installation of panic buttons.
i. A schedule is established for regular and deep cleaning of floors and maintenance and repair of ceilings.
j. Equipment and repair work orders are satisfactorily completed.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems – Security Needs Improvement

Conditions Needing Improvement. The following AIS security conditions require management attention:

Security Plans Were Not Comprehensive. The medical center's security plans, other than for Veterans Health Information Systems and Technology Architecture (VISTA), generally did not describe in sufficient detail:

- The systems and types of information processed.
- Authorized executable software permitted for use.
- Separation of duties.
- Internal controls designed to detect and minimize inadvertent and/or malicious modification or destruction of software and critical data files.

Contingency Plans Were Not Comprehensive. The medical center's contingency plans generally did not:

- Identify a disaster recovery team, or specify roles key personnel would play in the disaster recovery process.
- Identify an alternate processing facility that could be used during disaster recovery.
- Prioritize specific tasks and computer applications to be installed in a disaster recovery situation.
- Identify an off-station storage location for the contingency plan and back-up tapes.

AIS Back-up Tapes Were Not Stored Off-Station. Medical center staff stored AIS back-up tapes in the Agent Cashier's office on the first floor of the main hospital building. Storing computer back-up tapes so close to the main computer room risks destruction of the back-up tapes by the same catastrophic event affecting the main computer room.

The Information Security Officer (ISO) Was Organizationally Aligned Under the Chief Information Officer (CIO). The ISO was organizationally aligned under and reported to the CIO, who is responsible for operation of the AIS program. Since the ISO function is one of oversight, the individual in this position should not report to the manager responsible for the AIS program.

Information Management Service (IMS) Employees in Sensitive Positions Did Not Have Required Background Investigations. Background investigations had not been requested for 9 of the 46 IMS employees that required them. VA requires that personnel working in sensitive positions have background investigations performed commensurate with the sensitivity of their positions.

The ISO Did Not Perform Quarterly Reviews of the Continued Need for Remote Access. As of September 2002, the medical center had 627 remote access users. The ISO estimated that most employees who had remote access did not need the access, and the access should be terminated.

Major AIS Were Not Certified and Accredited. Major AIS including VISTA, Local Area Network, Exchange, and Private Branch Exchange were not certified and accredited in accordance with current VA policy requiring accreditation every 3 years by VA's Office of Cyber Security. The AIS had not been accredited since June 1997. Since the certification and accreditation of AIS is now the responsibility of the Office of Cyber Security, we made no recommendations for corrective action to the Medical Center Director.

Recommended Improvement Action 2. The VISN Director should ensure that the Medical Center Director takes action to ensure:

a. Security and contingency plans are comprehensive.
b. Back-up tapes are stored off-station.
c. The ISO is aligned under the Director's Office.
d. Background investigations are performed for all sensitive IMS positions.
e. Quarterly reviews of remote access users are performed.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Part-Time Physician Timekeeping – Controls Should Be Strengthened

Conditions Needing Improvement. Controls over part-time physicians' time and attendance should be strengthened:

Part-Time Physicians Did Not Have Designated Core Hours. None of the 64 (40 Surgical Service and 24 Medical Service) part-time physicians reviewed had designated core hours. VA policy requires that part-time physicians should designate at least 25 percent of their regular biweekly tours of duty as core hours. We randomly selected 10 of the part-time physicians to determine if they were present during their scheduled tour of duty. All 10 part-time physicians were present when we checked.

Subsidiary Time and Attendance Reports Were Not Used. None of the 64 part-time physicians reviewed had Subsidiary Time and Attendance Report-Part-Time Physicians (VA Forms 4-5631a) on file. VA policy requires that VA Forms 4-5631a be properly completed, certified, and filed by leave year for retention by the unit timekeeper for 3 years or until after a General Accounting Office audit.

Refresher Training Was Not Accomplished As Required. The Employee Accounts Section staff did not provide annual refresher training. The 14 timekeepers responsible for the part-time

physicians' time and attendance records have not received refresher training in the past 3 years. Employee Accounts Section staff should provide annual refresher training to all unit timekeepers to ensure that they maintain the highest possible degree of proficiency in all timekeeping and leave recording functions.

Semi-Annual Desk Audits of Unit Timekeepers Were Not Performed. The Employee Accounts Section staff did not perform semi-annual desk audits of timekeepers' records to determine whether timekeepers were properly reporting part-time physicians' time and attendance, as required by VA policy.

Recommended Improvement Action 3. The VISN Director should ensure that the Medical Center Director requires that:

a. All part-time physicians designate at least 25 percent of their regular biweekly tours of duty as core hours.
b. All part-time physicians complete Subsidiary Time and Attendance Reports, and unit timekeepers retain the records for 3 years.
c. Annual refresher training is provided to unit timekeepers.
d. Employee Accounts Section staff conduct semi-annual desk audits of timekeepers' records.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Contracts – Transcription Contract Payments Were Made Without Verifying That Services Were Received

Conditions Needing Improvement. The Contracting Officer Technical Representative (COTR) certified contract payments without verifying that the transcription services were received. The medical center's 5-year transcription contract is valued at $3.9 million and will end on September 30, 2003. From the inception of the contract on October 1, 1998, through September 18, 2002, the COTR did not verify any of the invoices, totaling about $3 million.

The contract required that the vendor provide the medical center with a daily log of all dictation, including the number of lines for each job. We found that medical center staff had never asked for, or received, daily logs from the vendor. To determine whether the medical center was being properly billed, we asked the COTR to provide a log of all jobs showing the number of lines billed on the August 2002 invoice. The COTR asked the vendor to provide support for the August 2002 invoice, but the data provided only included 404,294 of the 462,939 lines billed. No support was provided for the remaining 58,645 lines (13 percent).

At our request, the Chief, Health Information Management Service (HIMS) followed up with the vendor to obtain support for the remaining 58,645 lines, valued at about $9,100. According to the Chief, HIMS, the vendor informed her that their computer's hard drive crashed while they

were retrieving the remaining support for the August 2002 invoice. The vendor later told the Chief, HIMS, that the hard drive crash deleted all of the jobs performed since the inception of the contract on October 1, 1998. Consequently, the vendor could not provide support for any of the jobs performed under the contract, including support for transcription services provided, but not billed, during September and October 2002. As a result of the crash, the medical center reported it could not determine if they were properly billed for transcription services provided by the vendor throughout the course of the $3.9 million contract. The COTR is establishing a process to verify invoices prior to payment for the remainder of the contract period.

Recommended Improvement Action 4. The VISN Director should ensure that the Medical Center Director requires that:

a. The COTR establishes an effective process to verify invoices.
b. Contract requirements are enforced by ensuring the vendor provides a daily log of all transcriptions, including the number of lines for each report, to facilitate verification.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Pharmacy Security – The Physical Security of the Outpatient Pharmacy Should Be Improved

Conditions Needing Improvement. Pharmacy Service management did not provide proper security for its dispensing personnel. Dispensing staff were separated from patients picking up their medications by a low counter. There were no dispensing windows, no panic buttons, and the door between the outpatient dispensing area and the drug storage area remained open. VA policies require that dispensing windows must meet the Class III Ballistic Level and that all outpatient controlled substances awaiting patient pickup be stored in a locked area. Police and Security Service reported in its December 2000 Physical Security Survey that the doors of the outpatient pharmacy dispensing area must remain closed at all times. At the time of our review, we observed that medical center employees in the outpatient pharmacy dispensing area did not employ this safeguard.

Recommended Improvement Action 5. The VISN Director should ensure that the Medical Center Director require that physical security of the outpatient pharmacy dispensing areas is brought into compliance with VA standards.

The VISN and Medical Center Directors agreed with the finding and recommendation, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Should Be Strengthened

Conditions Needing Improvement. During the 22-month period ending July 2002, cardholders made about 124,000 purchase card transactions totaling $62.9 million. The following two conditions required management attention:

Purchase Card Transactions Were Not Approved Timely. Cardholders had not completed the necessary certification to transmit purchase card transactions to the approving officials for approval. At the time of our review, 2,776 purchase card transactions valued at about $1.6 million had not been approved. The average age of these transactions was 285 days, ranging from 15 to 680 days.

Quarterly Audits of Cardholder Accounts Were Not Conducted. According to the Chief, Accounting Section, quarterly audits have never been conducted. Quarterly audits are required of all purchase cardholder accounts that are not reviewed during the monthly statistical sampling audits conducted for the VA Financial Service Center. The quarterly audits of the Government Purchase Card would have identified the untimely approvals of transactions discussed above.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that:

a. Cardholders fully complete the reconciliation process for Government purchase card transactions.
b. Quarterly audits are conducted of all purchase cardholder accounts not reviewed during the monthly audits conducted by the VA Financial Service Center.

The VISN and Medical Center Directors agreed with the finding and suggestions, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Quality Management – Improved Follow Up of Root Cause Analyses Is Needed

Conditions Needing Improvement. QM employees did not track corrective actions recommended by Root Cause Analysis (RCA) teams until resolution. RCA teams conducted comprehensive RCAs; however, in four of five RCAs reviewed, all aspects of the corrective action plans were not implemented, and the effectiveness of corrective actions was not evaluated.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that RCA recommendations are tracked until issues are resolved.

The VISN and Medical Center Directors agreed with the finding and suggestion, and the VISN Director concurred with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Appendix A

VISN 8 Director Comments

DEPARTMENT OF VETERANS AFFAIRS
VA Sunshine Healthcare Network

VISN 8
P. O. Box 406
Bay Pines, FL 33744

Office: (727) 319-1125 Fax: (727) 319-1135

April 4, 2003

In reply refer to: Project No.
2002-03094-R3-0151

James R. Hudson
Director, Atlanta Audit Operations Division
1700 Clairmont Rd.
Decatur, GA 30033

Dear Mr. Hudson:

Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the James A. Haley Veterans' Hospital Tampa, FL. I have thoroughly reviewed the report and although I may not fully concur with all of the findings, I appreciate the review that was conducted as well as the recommendations that were generated in the report. As I was not present during the inspection in September 2002, I cannot comment on the physical environment reported by the OIG nearly 8 months ago. However, I would like to take this opportunity to speak to the status of the current environment.

Recently, I personally led a team of professionals on a site visit to the facility, including a Quality Management Officer, Safety Officer, Construction Specialist, Information Officer, Compliance Officer and Financial Officer, to review the Opportunities for Improvement addressed in the report. We found that although the facility is aging and requires constant attention, all areas were clean and well taken care of. All of the recommendations had been addressed and most actions have either been completed or are nearly complete. The specifics are addressed in our enclosed response.

I have implemented a program where a team will visit each facility in our VISN every quarter to monitor all environment of care standards, including security of pharmaceuticals. A full report of all findings will be submitted to the Medical Center Director for immediate action and a copy to me for continued follow-up. In addition, I have charged our Compliance Officer with conducting routine audits of Part Time Physician Time & Attendance. Finally, we are creating a Business Office that will have oversight of all financial transactions, including purchase card procurements, charges for transcription and other contracting services.

Appendix A

Page 2

With these measures in place, I am confident that future visits by the OIG or any accrediting body will result in a highly positive outcome. I would like to extend an invitation to you and your staff to re-visit our Tampa facility at any time to inspect the progress that has been made toward addressing the recommendations.

Thank you again for your review.

Sincerely,

Elwood J. Headley, M.D.
Network Director, VISN 8

Enclosure

Appendix A

Combined Assessment Program (CAP) Review (Dated OIG Draft 3/13/03)
Project Number 2002-03094-R3-0151
James A. Haley Veterans' Hospital
Tampa, Florida

The James A. Haley Veterans' Hospital response to this OIG Report is as follows:

Improvement Action 1: We recommend that the VISN Director ensure that the Medical Center Director takes action to ensure:

a. Patient care and common areas are routinely inspected and kept in a safe and clean condition.
Comments: Concur. Although this finding does not reflect the overall clean and safe hospital environment of the medical center, at the time of the review there were areas that needed to be improved. Multi-disciplinary "environment of care rounds" are undertaken each Friday morning ensuring that common areas are inspected as well as specific "zone" areas of the hospital are inspected at least semi-annually with documented follow-up actions. The recent reorganization combining Engineering and Environment Management Services into Facilities Management has resulted in improved safety and cleanliness throughout the hospital, with heavy patient usage areas such as lobbies and public bathrooms receiving more frequent cleaning. An on-going supervisory review process has been implemented to ensure compliance and a schedule of the Administrative/ Clinical Rounds for 2003/2004/2005has been established. A roofing project above the hemodialysis unit resulted in incidental debris in the lighting fixture. The fixture was cleaned and the leak and damaged ceiling tile over the pyxis supply room that was identified in the report was repaired immediately on 9/18/02.
[Action Complete with Continuous Monitoring].

b. Hazardous cleaning supplies are secured.
Comments: Concur. Environmental Management employees have received supplemental training on security of hazardous cleaning supplies. These supplies are secured in lockable areas on supply carts and in housekeeping aid closets.
[Action Complete with Continuing Monitoring].

Special Comment: Please note in relation to recommendations 1a and 1b that this review took place immediately prior to the arrival of a new Environmental Management Section Manager. This individual has developed and deployed an aggressive plan for initial training of Housekeeping aids. Furthermore he has established a comprehensive review process in high volume and high-risk clinical areas in order to ensure a high level of sanitation and corresponding cleanliness.

c. Compliance with Fire and Safety codes regarding fire apparatus.
Comments: Concur: The hospital maintains a monthly inspection program of all 651 fire extinguishers throughout the campus in compliance with JCAHO standard EC 2.10.2 and NFPA, Chapter 10. Hospital Policy Memorandum (HPM) 138-16, Fire Protection Systems Testing/Inspection, dated September 2001, Part 3. Delegation of Authority, A. indicates, " the Safety Engineer is responsible for ensuring that the fire suppression equipment tests and inspections performed by the Safety Technician are accomplished as scheduled and required by this policy". Additionally in Part 4 of this policy under Procedures, A. Inspections, indicates " all fire extinguishers shall be inspected monthly and shall have annual maintenance performed by a certified commercial firm."
Monthly Schedules for Inspection of Fire Extinguishers are completed by the safety staff. A commercial firm completed the 2002 annual inspection. For 2003, the annual commercial firm certification is scheduled for April 2003. A policy directive from HPM 138-26, entitled Safety, Occupational Health and Fire Prevention, dated September 2001, Part 9. Equipment Inspection, Testing and Maintenance, states that "all fire protection and life safety systems, equipment and components are inspected in accordance with National Fire Protection Association".
[Action Complete].

Appendix A

d. Compliance with VHA regulations concerning security and storage of medications.
Comments: Concur. Hospital Policy Memorandum 137-01, entitled Environmental Services Responsibilities, dated October 1999, Part E. Joint Responsibility of Services, states that contents and temperatures of refrigerators storing medications are checked daily by Nursing Service with weekly cleaning completed by Environmental Management Service. Daily logs are maintained on all refrigerators. Environmental Safety Monthly Records are maintained. Validation of compliance with the policy is accomplished through Environment of Care rounds.
[Action Complete with Continuous Monitoring].

e. Damaged recovery room stretcher mattresses are replaced.
Comments: Concur. New stretchers with new pads and mattresses were ordered on March 27, 2003 and are scheduled for delivery on or before April 26, 2003.
[Target date for Completion: Delivery 4/26/03].

f. Crash carts and defibrillators are properly checked and documented.
Comments: Concur. The policies that address both the crash carts and the defibrillators are being reviewed and revised to reflect a consistent process. Both the crash carts and the defibrillators will be checked and tested once a day when the area is open for business except for in the Emergency Room and Intensive Care Units where they will be checked once per shift (either Q 8 hours or Q 12 hours depending on the established tour of duty). Documentation will be present on the appropriate checklist. Once the lock has been broken a replacement cart will be issued to the area and the original cart will be returned to Pharmacy for restocking. This is the current practice.
[Target date for policy completion June 2003].

g. The standard of care for sedated patients is met in the Dental Clinic.
Comments: Concur. An Automated External Defibrillator (AED) was placed into service in the Dental Clinic in January 2003 and appropriate training completed on January 28, 2003. The AED equipment is self-testing and only requires an annual preventive maintenance (pm) check by biomedical engineering.
[Action Complete].

h. The Prevention of Violence in the Workplace Subcommittee addresses the installation of panic buttons.
Comments: Concur. The Prevention of Violence in the Workplace Subcommittee considers requests for panic buttons on a regular basis. All requests are considered against established criteria supplemented with specific multi-disciplinary reviews at requestor sites by concerned members of the Subcommittee. Police and Security perform alarm checks monthly.
[Action Complete].

i. A schedule for regular and deep cleaning of floors, as well as maintenance and repair of ceilings is established.
Comments: Concur. Deep cleaning of floors and the repair of ceilings is scheduled and completed based on need, and with regard to proper management of asbestos abatement control procedures. Cleaning Frequency schedule indicates all items and the frequency of cleaning. In the Nutrition and Food Service kitchen, a new chemical is being used for deep cleaning of floors, stainless steel panels were installed, replacing chipped tiles, and new washable ceiling tiles and painted ceiling grids have been installed. Break-Up, a Johnson Wax Professional product, is the new chemical being employed for deep cleaning.
[Action Complete].

j. Equipment and repair work orders are satisfactorily completed.
Comments: Concur. Work orders are managed through Engineering's AEMS/ MERS system and are prioritized based on specific engineering related needs and workload. Of interest, in FY 2002 Tampa completed 17,399 work orders. Any pending work orders are those that require extensive evaluations, such as asbestos are completed as soon as possible. HPM 138-02, entitled Engineering Maintenance, dated September 2001, describes the process for submission of Electronic Work Order Requests and HPM 138-05, entitled Work Order Requests and Computer Inputs, dated April 1998, describes in Part 4 Procedures, E. the work priority codes on all work orders. The recent reorganization of Engineering and Environmental Services has helped expedite the processing of work orders and the backlog has been significantly reduced.
[Action Complete].

Appendix A

Improvement Action 2: The VISN Director should ensure that the Medical Center Director takes action to ensure:

a. Security and contingency plans are comprehensive.
Comments: Concur. The existing security plan for VistA is comprehensive and the overall System Security Plan is being reviewed and revised. Expected completion date is May 2003.
[Target Date for Completion: 5/03].

b. Back-up tapes are stored off-station.
Comments: Concur. AIS back-up tapes have been moved and are now stored in Bldg. 42, which is off-site from the main campus, in an approved fireproof safe utilizing required security procedures.
[Action Complete].

c. The ISO is aligned under the Director's Office.
Comments: Concur. An organizational change was implemented 9/26/02 with the ISO aligned under the Director's Office.
[Action Complete].

d. Background investigations are performed for all sensitive IMS positions.
Comments: Concur. Background investigations were initiated on 9/23/02 for the nine IRMS positions identified in the report. Tampa's request was submitted to the VHA Deputy Secretary for Security and Enforcement and subsequently to the Office of Personnel Management. This process normally requires at least six months; however in view of increased security requests from other organizations, this request is projected to take more time. We are awaiting the final response from OPM.
[Partially Complete - Target date for Completion: 9/03].

e. Quarterly reviews of remote access users are performed.
Comments: Concur. A review process for quarterly remote access users has been completed that will comply with VHA Regulations. The first quarterly review is scheduled for end of 2nd Quarter FY 2003.
HPM IMS-8, entitled Remote Access Server Procedures, dated December 2000 outlines the hospital's policy governing remote access. The ISO monitors and documents remote access usage on a daily basis. Access for any employee who does not utilize remote access in the previous 90 days is terminated. A quarterly review is scheduled for the end of 2nd Quarter, FY 2003.
[Target Date for Completion 5/03].

Improvement Action 3: The VISN Director should ensure that the Medical Center Director requires that:

a. All part-time physicians designate at least 25 percent of their regularly bi-weekly tours of duty as core hours.
Comments: Concur. Tampa now requires all part-time physicians on adjustable tours have an established bi-weekly tour of duty, of which a minimum of 25% of these hours is designated "Core Hours." This requirement of 25% for designated core hours is documented in Hospital Policy Memorandum 05-23, dated March 2003 and complies with VHA Regulations and the OIG recommendation. This policy has been reviewed with the Clinical Service Chiefs and with the University of South Florida Health Science Center (Medical School) executives in several training conferences.
[Completed Action 4/03].

b. All part-time physicians complete Subsidiary Time and Attendance Reports, and unit timekeepers retain the records for 3 years.
Comments: Concur. This issue has been addressed in HPM 05-23 mentioned above. All part-time physicians will be required to have Subsidiary Time and Attendance Reports (VAF 4-5631a) and electronic equivalent (for paperless storage and certification), properly completed, certified and retained by unit timekeepers for three years. This revised timekeeping procedure will be implemented effective 4/6/03, following appropriate unit timekeeper training necessary to implement this OIG recommendation. The Payroll Section of Fiscal Service has completed this training. The appropriate Service Chiefs of part-time physicians must certify the accuracy of timekeeping records and documentation each pay period.
[Partially Completed Action. Target Date for Completion: 4/03].

Appendix A

c. Annual refresher training is provided to unit timekeepers.
Comments: Concur. Annual refresher training will be available as a web based class on the intranet: http://vaww.tampa.med.va.gov/education_css/index.php. The web-based training is undergoing final review (adding part-time physician timekeeping procedures to training) and this proposed innovation is viewed as a "Best Practice" and will be suggested for national implementation through appropriate channels.
[Target Date for Completion 5/03].

d. Employee Accounts Section staff conduct semi-annual desk audits of timekeepers' records for part-time physician' time and attendance, as required by VA policy.
Comments: Concur. A process and schedule for semi-annual desk audits has been completed utilizing Fiscal Service Payroll staff and audit reviews will be completed as scheduled.
[Target Date for Completion: 6/03].

Improvement Action 4: The VISN Director should ensure that the Medical Center Director requires that:

a. The COTR establishes an effective process to verify invoices.
Comments: Concur. The COTR in the Business Office established a process in August 2002, however, this process had just been implemented and required further refinements and or adjustments. Currently the Business Office verifies the accuracy of submitted transcription invoices using a line count. The goal is to virtually eliminate contract transcription services (by 90%) utilizing " VHA on-staff transcription personnel" and "voice recognition" technology systems.
[Target Date for Completion: 6/03].

b. Contract requirements are enforced by ensuring the vendor provides a daily log of all transcriptions, including the number of lines for each report, to facilitate verification.
Comments: Concur. The Vendor has been notified in writing that the requirements stated in the Work Statement of the original Contract must be adhered to. These requirements include the daily log of dictations, the length of dictations and backlog status which are being manually "validated by a random sampling review process" involving 2.5 FTEE in the Business Office, verifying the accuracy of the Contractor's information.
[Action Complete].

Improvement Action 5: The VISN Director should ensure that the Medical Center Director requires that physical security of the outpatient dispensing areas is brought into compliance with VA standards.

a. Pharmacy Security - The physical security of the outpatient pharmacy should be improved.
Comments: Concur. Pharmacy has assessed the security risk and an NRM project is proposed for FY 04 funding to improve (completely re-design) the outpatient pharmacy consultation/processing area. Interim improvements already implemented include: security related signs have been posted, controlled substances are now stored in the main outpatient area where they are double-locked, and the door between the areas are secured. Additionally requested improvement items include panic buttons for the consultation/processing area, close-circuit camera for the pick-up area monitored by VA Police, and Plexiglas panels to discourage patients from attempting to enter pick-up areas.
[Partial Completion with Target Date for full Completion FY 2004].

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that:

a. Cardholders fully complete the reconciliation process for Government purchase card transactions.
Comments: Concur. All 2,776 purchase card transactions have been corrected and approved. Fiscal Service is using the IFCAP YTD Detail Accrual Report to identify incorrectly reconciled transactions that have not appeared as unapproved transactions through other reporting mechanisms, and that required corrective actions to fully meet VHA regulations.

To prevent future recurrence, the Chief, Accounting Section has requested and received this menu option (IFCAP YTD Detail Accrual Report) to conduct a weekly review of all un-reconciled transactions. The Acting Chief, Fiscal Service has approved this process improvement and this change was implemented in November 2002.
[Action Complete]

Appendix A

b. Quarterly audits are conducted of all purchase cardholders accounts not reviewed during monthly audits conducted by the VA Financial Service Center.
Comments: Concur. The quarterly audits of purchase cards will be conducted.
[Partial Completion with Target Date for full Completion 12/03].

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director requires that RCA recommendations be tracked until issues are resolved.

Comments: Concur. Quality Improvement hired a new Patient Safety Manager in August 2002. This individual has reviewed all RCA's and subsequent follow-up corrective actions. These follow-up corrective actions have been monitored for completion with pending action items being referred for discussion and assistance for final disposition and or completion. A review of five RCA's (LO0013 through LO0018, excluding LO0017; indicates that 11 of the 12 action items have been implemented. One action item is pending further review and analysis for disposition. L00017 requires establishment of a new position, which is being evaluated. The CEB and ASC will review pending items in their April 2003 meetings. RCA action item discussions will be a recurring agenda item.
[Action Complete].

Appendix B

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- Committee on Governmental Reform, U.S. House of Representatives

Appendix B

Committee on Veterans' Affairs, U.S. House of Representatives
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This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.