Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00054-218

Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System Gainesville, Florida

August 10, 2010

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of April 19–23, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the North Florida/South Georgia Veterans Health System (the system), Gainesville, FL. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 481 system employees. The system is part of Veterans Integrated Service Network (VISN) 8.

Results of the Review

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

- Heart Failure (HF) Program
- Patient Education Program
- VA Nursing Academy (VANA)

We made recommendations in seven of the activities reviewed. For these activities, the system needed to ensure compliance with Veterans Health Administration (VHA) policies and other external standards related to:

- Magnetic Resonance Imaging (MRI) Safety
- Environment of Care (EOC)
- Reusable Medical Equipment (RME)
- Coordination of Care (COC)
- Physician Credentialing and Privileging (C&P)
- QM
- Medication Management

The system complied with selected standards in the following activity:

- Suicide Prevention Safety Plans

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 20–25 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system consists of the Malcolm Randall VA Medical Center located in Gainesville, FL, and the Lake City VA Medical Center located in Lake City, FL. The system provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at nine community based outpatient clinics in Jacksonville, Tallahassee, Lecanto, Ocala, St. Augustine, The Villages, and Marianna, FL, and in Valdosta and St. Marys, GA. The system is part of VISN 8 and serves a veteran population of more than 360,000 throughout 31 counties in northern Florida and 19 counties in southern Georgia.

Programs. The system provides primary, tertiary, and specialty care services. It has 279 hospital beds and 264 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Florida and with the Florida State University, Santa Fe Community College, Lake City Community College, and Florida Agricultural and Mechanical University and provides training for 147 residents. In fiscal year (FY) 2009, the system's research program had 56 projects and a budget of $6 million. Important areas of research included brain diseases, vascular diseases, obesity, and rehabilitation.

Resources. In FY 2009, medical care expenditures totaled $803 million. The FY 2010 medical care budget is $800 million. FY 2009 staffing was 4,375 full-time employee equivalents (FTE), including 311 physician and 1,054 nursing FTE.

Workload. In FY 2009, the system treated 127,527 unique patients and provided 86,756 inpatient days in the hospital and 68,499 inpatient days in the CLC units. The inpatient care workload totaled 13,641 discharges, and the average daily census, including CLC patients, was 425. Outpatient workload totaled 1,264,605 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered system operations for FY 2009 and FY 2010 through April 19, 2010, and was done in accordance with OIG standard operating procedures (SOPs) for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, Florida,* Report No. 07-00542-179, August 1, 2007). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 481 employees. These briefings covered procedures for reporting suspected criminal activity

to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective action.

Organizational Strengths

Heart Failure Program

HF is a leading cause for hospitalization and death of VA patients and accounts for a disproportionate number of days spent in the hospital when compared with other chronic illnesses. The system recently implemented an HF program that includes outpatient disease management, home telehealth management, quality of life measurement, and an aggressive review of inpatient admissions for identification of at-risk patients in order to improve HF care. If an inpatient is identified as high risk, the HF Team offers HF-specific recommendations and education.

As a result of this novel approach, the system has seen a reduction in HF-specific and all-cause hospitalizations for HF patients, a reduction in HF length of stay, and a reduction in HF patient mortality rates.

Patient Education Program

System nursing staff led an initiative to assess health care literacy and focus on improving patient education. The initiative included advocating the use of a health literacy screening clinical reminder in the primary care clinics; launching "Teach for Success," a 2-day course that promotes skills in patient teaching and counseling; and introducing an in-house video on demand program.

The National Patient Safety Foundation endorsed a nomination for, and the authors—system employees—won, the Pfizer Health Literacy in Advancing Patient Safety Award, based on the article "Testing a Health Literacy Screening Tool: Implications for Utilization of a BRIEF Health Literacy Indicator," in the *Federal Practitioner.*[1]

[1] The Federal Practitioner is a monthly, peer-reviewed clinical journal with clinical review articles, original research, case reports, evidence-based treatment protocols, pertinent legal and ethical viewpoints, and in-depth profiles of new programs and procedures within the Federal health care system.

VA Nursing Academy

The Department of Veterans Affairs established a VANA to help address the nursing shortage within the VA as well as the Nation. This 5-year, $59 million program has 15 VA/nursing school partnerships, and the system was one of the first of four VA sites selected for the program. The program provides expanded teaching and research opportunities for VA nursing staff and provides clinical experiences for nursing students, leading to increased VA recruitment and retention of nurses.

The VANA program at the system, which partners with the University of Florida College of Nursing, has been highly successful and has earned national recognition. The program has increased nursing school enrollment at a higher rate than other VANA programs, and program faculty are recognized for their expertise in clinical education. In addition, the Registered Nurse Residency program at the system is the first program in VHA to seek accreditation. Since implementation of the VANA program, the system has reduced the nurse vacancy rate, almost fully eliminated reliance on agency nurse staffing, and has become the employer of choice in the community for new nursing graduates.

Results

Review Activities With Recommendations

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI areas. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI areas in Gainesville and Lake City, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety and infection control policies and had appropriately conducted a risk assessment of the environment, as required by The Joint Commission (JC).

We found that patients in the magnet rooms are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner.

We reviewed the medical records of seven patients who had an MRI with contrast media. None of the seven patients were determined to be high risk; therefore, signed informed consent was not required prior to their procedures. We identified the following conditions that needed improvement.

Safety. The local SOP states that registered radiologic technologists may inject contrast material via peripheral intravenous routes under the direction of a radiologist or designee. However, contrast must be part of the protocol initiated by the radiologist and must be ordered by a physician. MRI technicians at both Lake City and Gainesville were administering contrast to patients without a physician's order. Technicians told us that on occasion, if contrast was not ordered and a radiologist was not available for approval, the technician would administer it anyway if it was not contraindicated.

The Chief of Radiology Service denied knowledge of this condition. However, technicians told us it was their practice, and an approved skills checklist in their competency folders appeared to give them permission to make the decision to administer contrast. While we were onsite, Radiology Service managers created an action plan to correct the situation. The action plan includes development of a new SOP, education, modification of the skills checklist, and monitoring of compliance.

American College of Radiology (ACR) guidance states that zones of magnetic field hazard should be clearly delineated and that access should be appropriately restricted. Zone II is the interface between the publically accessible, uncontrolled Zone I and the strictly controlled Zones III and IV. Zone III regions should be physically restricted from general public access by locking systems or any other reliable, physically restricting method that can differentiate between MRI personnel and non-MRI personnel. All non-MRI personnel entering Zone III must pass an MRI safety screening and must be escorted by Level 2 MRI personnel at all times.

Although we found appropriate signage and barriers to prevent unauthorized or accidental access to the MRI areas in Gainesville, the configuration of the new MRI suite in Lake City was inconsistent with ACR guidance. Zones II and III were combined, and the check-in and waiting area for families was just outside the magnet room (Zone IV). Non-MRI personnel also had access to the check-in and

waiting area. Persons accessing the check-in and waiting area were not all screened as is required for entry to Zone III areas.

Screening Forms. The local SOP requires that physicians screen patients for contraindications for MRI or use of contrast at the time of the order. This is to be documented in the medical record. A second screening is required when the patient arrives for the MRI. We reviewed the medical records of 17 outpatients who had an MRI ordered. We found that 15 (88 percent) had evidence of physician screening at the time of the order. We found that 12 (86 percent) of 14 patients who received an MRI had evidence of two separate screenings. However, the signed, second screening forms were not scanned into the medical record and were only kept for 1 year. Therefore, they did not become a permanent part of the medical record.

Training. All personnel who have access to MRI areas must receive appropriate MRI safety training. We reviewed the training records of six Radiology Service personnel and six support personnel who had access to the MRI areas and found that only three of six Radiology Service staff and four of six support staff had evidence of annual training.

Recommendation 1 We recommended that the VISN Director ensure that the System Director implements the action plan to ensure that MRI technicians do not administer intravenous contrast material without physician authorization.

The VISN and System Directors concurred with the finding and recommendation. MRI staff have been educated, and the SOP has been modified to specify that an order by a physician is required for contrast administration. Monitoring of 30 cases during the month of May showed 100 percent compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director require that the System Director ensures that access to Zone III in the Lake City MRI suite is further restricted.

The VISN and System Directors concurred with the findings and recommendation. Access to Zone lll is now limited to patients only, and the door to Zone lll is locked at all times. Entry to Zone III is permitted only when escorted by MRI safety trained personnel. The designated waiting area for

MRI patients and families has been relocated to an appropriate area. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that signed screening forms become part of patients' medical records.

The VISN and System Directors concurred with the finding and recommendation. All MRI screening forms are now being scanned into the medical records. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that appropriate staff receive annual MRI safety training.

The VISN and System Directors concurred with the findings and recommendation. All Radiology Service staff have completed the appropriate training, and MRI safety training is now included in annual mandatory training requirements. The corrective actions are acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine whether the system maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), and JC standards.

At Gainesville, we inspected an acute inpatient surgical unit, an acute inpatient medical unit, the medical intensive care unit, the dialysis unit, the emergency department (ED), the locked inpatient mental health (MH) unit, the eye clinic, one CLC unit, and the main food preparation area. At Lake City, we inspected the intensive care unit, the step-down unit, the same day surgery unit, the hospice unit, the inpatient medical unit, three CLC units, the MH outpatient clinic, and the ED. We found that the system was generally clean and well maintained.

Centers for Disease Control and Prevention (CDC) guidelines recommend daily monitoring and documentation of negative air flow in isolation rooms when they are

occupied by patients. At Lake City, we found that the ED did not have a mechanism for monitoring and documenting occupied isolation room negative air flow. While we were onsite, managers provided us with an action plan to manually monitor and document negative air flow until installation of an electronic monitoring device system is completed. Therefore, we made no recommendation for this finding.

VHA requires[2] that furnishings in patient care areas of locked inpatient MH units be physically heavy or secured to the floor to prevent them from being moved, overturned, thrown, or used as weapons. At the Gainesville locked inpatient MH unit, we found that the dining room tables and chairs were neither heavy nor secured to the floor. Managers provided us with an action plan for staff presence or observation while patients are in the dining room. Therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

Environmental Rounds. VHA policy[3] requires that EOC rounds include participation by managers in nursing, building management, engineering, and safety; representatives from patient safety and infection control; and others, as required. We reviewed the system's EOC rounds attendance records for the 4th quarter of FY 2009 and the 1st quarter of FY 2010 and found that rounds were not consistently attended by the required team members or their designees. Missing team members included Nursing Service managers and patient safety representatives.

N95 Respirator Fit Testing. CDC guidelines recommend that all health care personnel entering rooms of patients with confirmed, suspected, or probable H1N1 influenza should wear, at a minimum, a fit tested N95 respirator.[4] In addition, OSHA standards require designated staff to be medically cleared, fit tested, and trained for respirator use as part of a complete respiratory protection program. At Gainesville, we found that 25 (74 percent) of 34 selected employees from bronchoscopy, Radiology Service, the acute inpatient medical unit, and the ED had not received annual N95 fit

[2] VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," January 4, 2010.
[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[4] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.

testing. At Lake City, we found that 11 (48 percent) of 23 selected employees from Radiology Service, the inpatient medical unit, and the ED had not received annual N95 fit testing.

Fire and Life Safety. The NFPA requires that fire drills be conducted once per shift per quarter in each building designated for health care occupancy. We reviewed fire drill records for the 3rd and 4th quarters of FY 2009 and for the 1st and 2nd quarters of FY 2010 for both Gainesville and Lake City and found that fire drills were not consistently conducted on the evening or night shifts.

Training. VHA policy[5] requires employees of locked inpatient MH units and members of the Multidisciplinary Safety Inspection Team to complete training on environmental hazards that represent a threat to suicidal patients. This training should occur initially during orientation and annually thereafter. We reviewed training records and found that 3 (16 percent) of 19 selected employees from the locked inpatient MH unit in Gainesville had not completed the required initial or annual training.

OSHA standards require that all employees with occupational exposure risk receive initial and annual training for bloodborne pathogens. We reviewed FY 2008 and FY 2009 training records from Nursing Service and Environmental Management Service (EMS). We found that 8 (20 percent) of 40 selected employees had not completed the required annual training.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that EOC rounds include participation by all required team members.

The VISN and System Directors concurred with the finding and recommendation. EOC rounds attendance documentation now includes the names and services of all participants. Attendance will be tracked and reported to the EOC Committee. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

[5] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that designated employees receive annual N95 respirator fit testing.

The VISN and System Directors concurred with the findings and recommendation. Service chiefs and supervisors will identify and request fit testing for appropriate staff. Testing will be done each month. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that fire drills are conducted in buildings designated for health care occupancy in accordance with NFPA regulations.

The VISN and System Directors concurred with the finding and recommendation. Quarterly drills in the appropriate areas on all shifts have been conducted. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that Nursing Service, EMS, and locked inpatient MH unit employees receive required training.

The VISN and System Directors concurred with the findings and recommendation. All required staff completed training as of June 25, 2010. The corrective action is acceptable, and we consider this recommendation closed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the system had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The system's Supply, Processing, and Distribution (SPD) and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected the SPD areas, the hemodialysis unit, and the gastrointestinal unit at Gainesville and the SPD area at Lake

City. We noted that traffic in the SPD areas was restricted to authorized personnel and that appropriate personal protective equipment was donned prior to entering the SPD reprocessing areas, as required.

We reviewed the competency folders and training records of nine employees who demonstrated reprocessing procedures and found that initial and annual competencies and training were current and consistently documented.

During the past 12 months, we noted that flash sterilization[6] rates were higher than the VISN goal of 2 percent of total surgical cases. However, rates met target goals for 3 of the last 4 months. Based on opportunities identified by trending flash sterilization log data, aggressive measures were taken to reduce the need for flash sterilization. New instruments were purchased, and vendors were notified regarding requirements for timely delivery of surgical supplies. Therefore, we made no recommendation for this finding.

At Gainesville, we found that an emergency action plan was not posted next to the gas sterilizer. VA policy[7] requires that a written emergency action plan be posted adjacent to the gas sterilizer. The action plan was easily located and posted in the proper place while we were onsite. Therefore, we made no recommendation for this finding.

We reviewed the SOPs for reprocessing for 12 pieces of RME. We found that 10 (83 percent) of the 12 SOPs were well developed and consistent with the manufacturers' instructions. While we were onsite, minor changes were made to two SOPs to reflect actual practice and be consistent with manufacturers' guidelines. Therefore, we made no recommendation for this finding.

We also found that actual practice demonstrated by one employee needed minor changes to be consistent with the SOP and manufacturer's guidelines. Appropriate skills were demonstrated by the SPD employee after the discrepancy was discovered. Therefore, we made no recommendation for this finding. However, we identified the following condition that needed improvement.

[6] Steam sterilization of unwrapped or individual items; usually used in an emergent or urgent situation.
[7] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements;* August 16, 2002.

Air Quality in SPD. VA requires[8] that there be 6 to 10 air exchanges per hour in areas where equipment is being decontaminated and/or reprocessed. Furthermore, air exchanges must be carefully controlled to minimize the movement of microorganisms from dirty areas to clean areas. We found that air exchanges in SPD sterile storage areas were less frequent than standards require.

VA requires[9] temperature to be maintained between 65 and 72 degrees and humidity to be maintained between 35 and 45 percent in all areas where sterile items are kept. Sterility of equipment kept in storage areas cannot be assured if temperature and humidity are not maintained at prescribed levels. We found that temperature and humidity were not adequately controlled in the Gainesville SPD sterile storage area; temperatures were higher than 72 degrees and humidity was widely variable.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that measures be taken to maintain temperature, humidity, and air exchanges in sterile storage areas at prescribed levels.

The VISN and System Directors concurred with the findings and recommendation. The system is seeking contract consultative services to review potential actions needed to maintain appropriate temperature, humidity, and air exchanges. The action plan is acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[10] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 24 discharged patients and determined that clinicians had generally documented the required elements. Also, we

[8] VA Handbook 7176.
[9] VA Handbook 7176.
[10] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

found that follow-up appointments occurred within the timeframes specified.

VHA requires that systems have a policy that ensures the safe, appropriate, and timely transfer of patients. We determined that the system had an appropriate transfer policy. However, we identified the following area that needed improvement.

Inter-Facility Transfers. VHA policy[11] requires specific information (such as the reason for transfer, mode of transportation, and informed consent to transfer) to be recorded in the transfer documentation. VHA also requires inter-facility transfers to be monitored and evaluated as part of the QM program.

We reviewed transfer documentation for 10 patients transferred from the system's acute inpatient units or ED to another facility. We found that none of the 10 patient records had all required documentation. Missing information included informed consent to transfer, advanced directive status, and requirements needed during transport. Local policy requires the use of VA Form 10-2649A, which contains all the required transfer documentation elements, and VA Form 10-2649B to obtain informed consent. We found that these forms were not being utilized. In addition, we did not find evidence that patient transfers were evaluated as part of the QM program.

Recommendation 10 We recommended that the VISN Director ensure that the System Director requires compliance with VHA and local policy regarding inter-facility transfers.

The VISN and System Directors concurred with the findings and recommendation. All employees were informed that VA Forms 10-2649A and 10-2649B are to be completed by a physician for all inter-facility transfers. Compliance will be monitored through QM, and findings will be reported to the Chief of Staff (COS) for appropriate follow-up. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Physician Credentialing and

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a

[11] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Privileging

sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[12] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and provider profiles and found that licenses were current and that primary source verification had been obtained. We also reviewed Focused Professional Practice Evaluations (FPPEs) and Ongoing Professional Practice Evaluations (OPPEs) for required criteria. We identified the following areas that needed improvement.

FPPE. VHA requires[13] a review process to ensure the competence of newly hired physicians. We found that FPPEs for two of the five newly hired physicians lacked required provider-specific data and signatures. We also found that the results of completed reviews were not reported to the Medical Executive Committee, as required.

OPPE. VHA also requires that specific competency criteria for OPPE be in place for all privileged physicians. We found OPPE data for only two of the five physicians seeking reprivileging.

Provider Profiles. VHA policy requires that service chiefs collect and monitor provider-specific performance data for all physicians. We found provider profiles for only 8 (80 percent) of 10 physicians in our sample.

Recommendation 11 We recommended that the VISN Director ensure that the System Director requires that FPPE, OPPE, and provider profiles are in compliance with VHA requirements.

The VISN and System Directors concurred with the findings and recommendation. Training sessions were conducted, and process changes were implemented. External reviews noted improvement, and The JC was complimentary of current practice. The corrective actions are acceptable, and we consider this recommendation closed.

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of

[12] A file of provider-specific data utilized to assist service chiefs and medical staff leadership in the privileging and reprivileging processes.
[13] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director, the COS, and QM personnel. We evaluated policies, performance improvement (PI) data, and other relevant documents.

The system's QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives, and through allocation of resources to the program. Appropriate review structures were in place for most program activities reviewed; however, we identified the following area that needed improvement.

Life Support Certification. VHA requires[14] that each medical facility have a policy determining which staff require training for Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) and that a mechanism is in place to monitor compliance. The system had a policy in place; however, we found that only 139 (87 percent) of 160 physicians required to have BLS certification were current and that only 164 (84 percent) of 195 physicians required to have ACLS certification were current. We also found that only 267 (90 percent) of 298 nursing employees required to have ACLS certification were current.

Recommendation 12 We recommended that the VISN Director ensure that the System Director requires that designated employees maintain current life support certification.

The VISN and System Directors concurred with the findings and recommendation. All services will identify staff required to have BLS and ACLS certification. Compliance will be monitored and reported quarterly. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients and CLC residents.

The system had implemented a practice guideline governing

[14] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[15] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Additionally, clinical staff followed the established protocol when a delay in receipt of influenza vaccines was experienced, as required. However, we identified the following area that needed improvement.

CLC Influenza Vaccinations. VHA requires[16] that several items be documented for each influenza vaccine given, including the route, site, and date of administration. We reviewed the medical records of 10 CLC residents and found that only 7 (70 percent) of the 10 records contained documentation of all required elements.

Recommendation 13 We recommended that the VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

The VISN and System Directors concurred with the finding and recommendation. The vaccination/skin test template has been revised to include all required elements, and monitoring for compliance will take place during the influenza season. The corrective actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behaviorally oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help.

[15] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[16] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.

Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[17]

A previous OIG review of suicide prevention programs in VHA facilities[18] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 21 patients assessed to be at high risk for suicide between August 2009 and February 2010 and found that clinicians had developed safety plans for 17 (89 percent) of the 19 appropriate patients.[19] The 17 plans included all required elements. We also found evidence to support that the patients participated in the development of the plans.

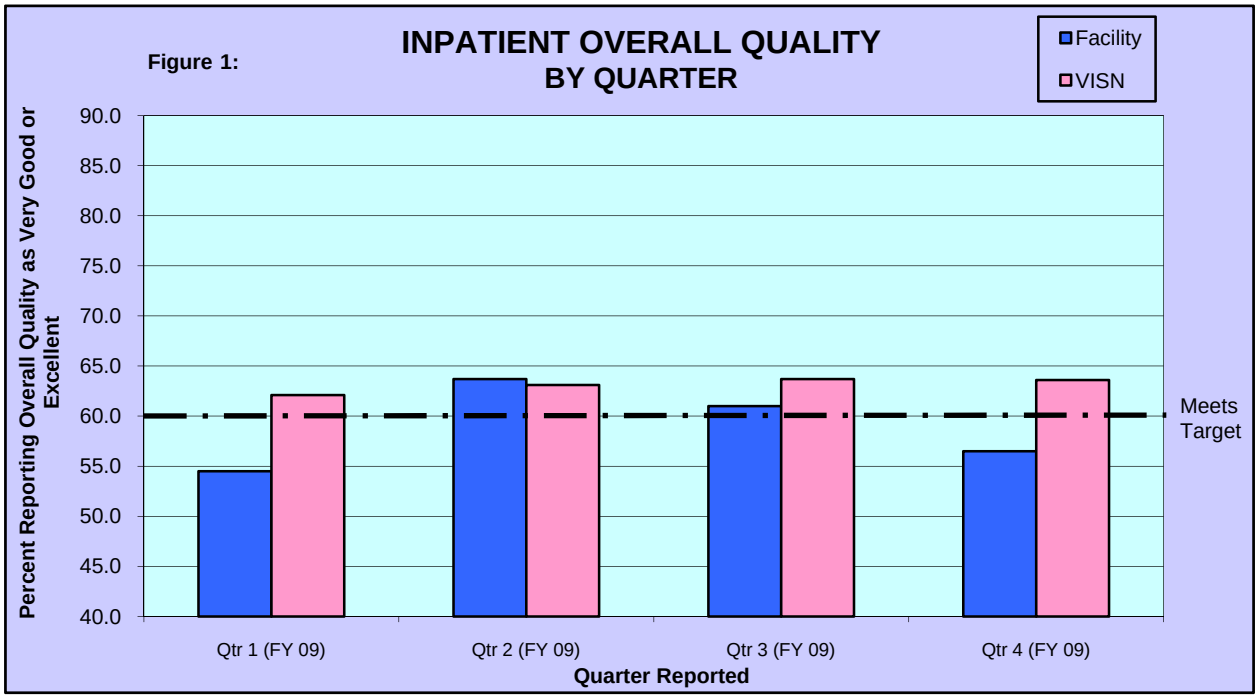
Although not a requirement, the system had implemented a policy requiring that safety plans be developed by the time of discharge for inpatients and by the second MH visit following placement on the high-risk list for outpatients. Documentation showed that Suicide Prevention Program staff provided excellent case management for high-risk patients and wrote progress note reminders if safety plans had not been developed within required timeframes. We made no recommendations.

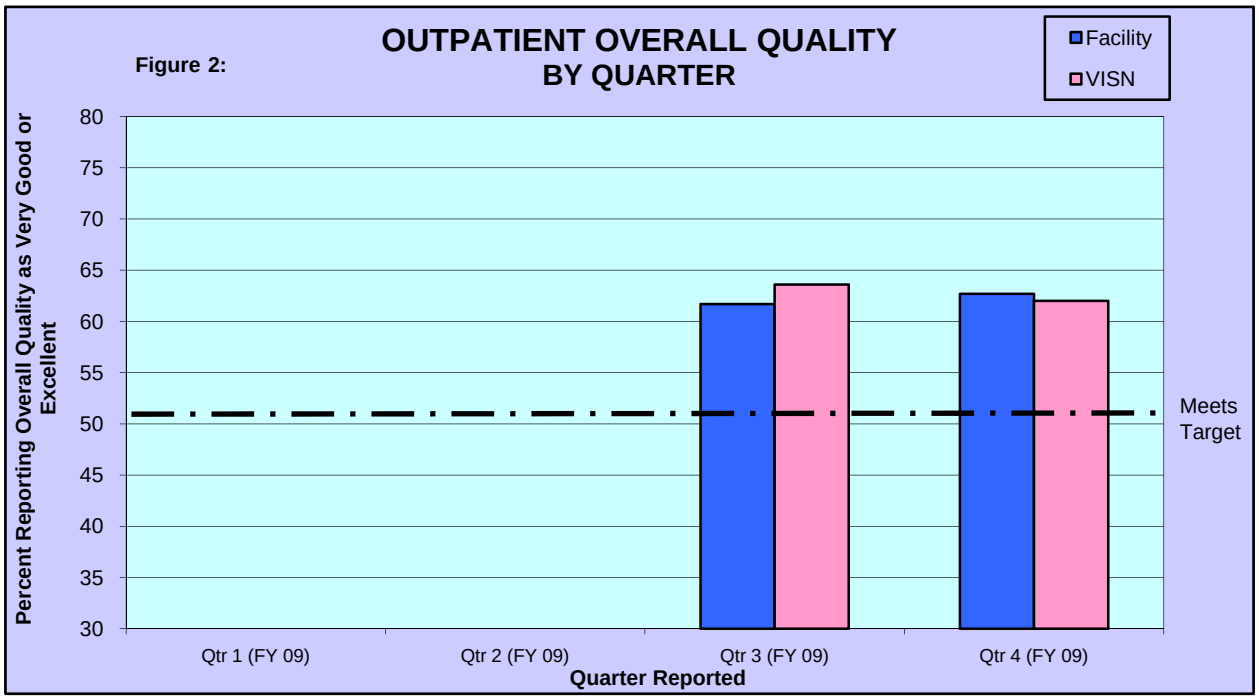
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1–4 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of

[17] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[18] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.
[19] One patient was terminally ill and placed on the list after a suicide attempt. He was hospitalized from the time of placement until his death 5 days later. A plan was not created. Another patient refused to attend any MH appointments or have contact with MH staff. His safety was verified by his attendance at primary care appointments. No plan could be created as patient did not want to participate.

FY 2009.[20] The target scores are noted on the graphs.



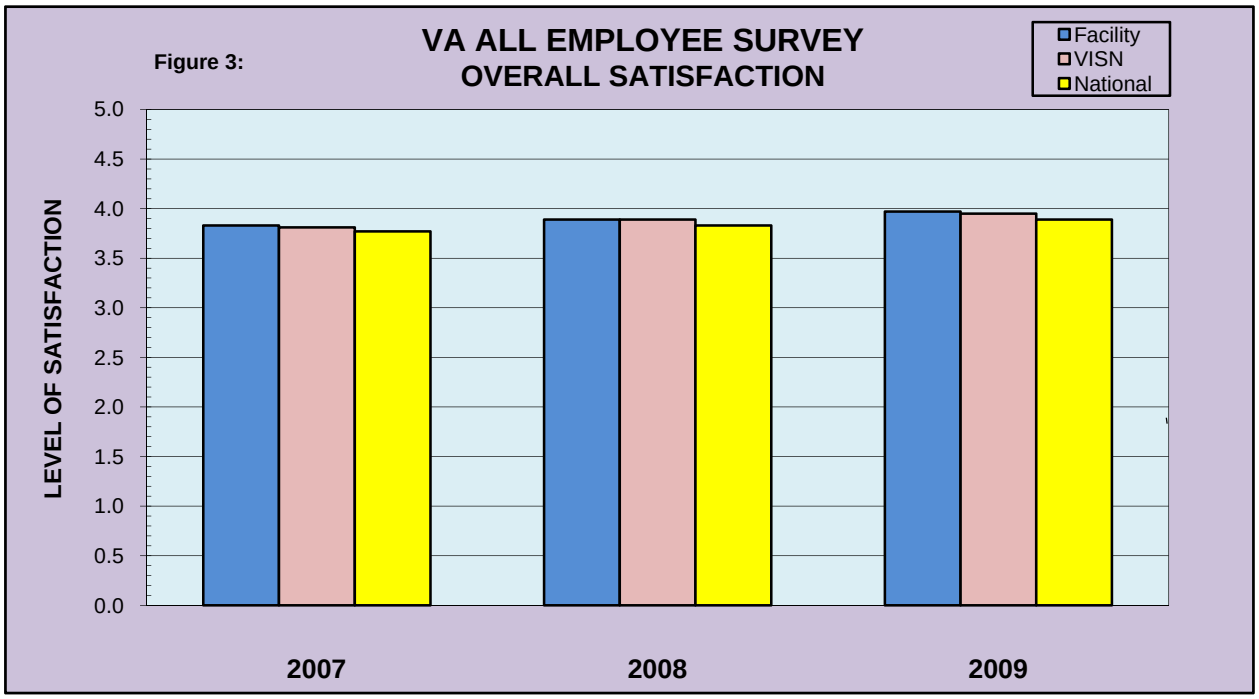


Employees are surveyed annually. Figure 3 on the next page shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been

[20] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 3:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 2, 2010

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, FL**

To: Associate Director, St. Petersburg Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I concur with the findings and recommendations in the report of the Combined Assessment Program Review.

Nevin M. Weaver

Nevin M. Weaver, FACHE
VISN 8 Network Director

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 30, 2010

From: Director, North Florida/South Georgia Veterans Health System (573/00)

Subject: **Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System, Gainesville, FL**

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)
THOMAS A. CAPPELLO, MPH, FACHE

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director implements the action plan to ensure that MRI technicians do not administer intravenous contrast material without physician authorization.

Concur

MRI staff have been educated and an SOP modified to specify an order by a physician is required for contrast administration. All MRI requests are screened and protocol reviewed by the Radiology Resident or Attending Radiologist prior to performance of the exam. The Radiologist orders contrast if indicated. Techs are not allowed to administer contrast without the physician order. Monitoring of 30 cases during the month of May confirmed 100 percent compliance. Recommend closure of this item.

Recommendation 2. We recommended that the VISN Director require that the System Director ensures that access to Zone III in the Lake City MRI suite is further restricted.

Concur

Access to Zone lll is now limited to patients only and the door to Zone lll is locked at all times. Entry into Zone lll is permitted only when escorted by MRI safety trained personnel. A designated waiting area for MRI patients and families in the main hospital is available and being utilized. Recommend closure of this item.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that signed screening forms become part of patients' medical records.

Concur

All screening forms (100 percent) are being sent to Health Information Management Service (HIMS) to be scanned into the medical record. Recommend closure of this item.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that appropriate staff receive annual MRI safety training.

Concur

All radiology staff (100 percent) have received appropriate training. MRI training is being added to mandatory training for personnel. Recommend closure of this item.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that EOC rounds include participation by all required team members.

Concur

Attendance is now appropriately documented at EOC rounds to include the name and service of each participant. This data will be tracked and reported to the EOC Committee beginning July 2010.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that designated employees receive annual N95 respirator fit testing.

Concur

Service chiefs and supervisors will identify and request fit testing for designated staff with the N95 respirator. Testing is done each month on selected days or as requested. GNV currently has 757 staff fit tested. Lake City currently has 740 staff fit tested. All required/requested testing has been scheduled. New requests will be scheduled upon identification. Recommend closure of this item.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that fire drills are conducted in buildings designated for health care occupancy in accordance with NFPA regulations.

Concur

This deficiency was identified by staff prior to the survey. Immediate action was taken to implement practices requiring quarterly drills on all three shifts. Drills are up to date. Recommend closure of this item.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that Nursing Service, EMS, and locked inpatient MH unit employees receive required training.

Concur

As of June 25, 2010, all staff have completed required training. Recommend closure of this item.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that measures be taken to maintain temperature, humidity, and air exchanges in sterile storage areas at prescribed levels.

Concur

We are seeking contract consultative services to review potential actions needed to maintain appropriate temperature and humidity. Tentative date for consultative service is October 15, 2010.

Recommendation 10. We recommended that the VISN Director ensure that the System Director requires compliance with VHA and local policy regarding inter-facility transfers.

Concur

1. A bulletin was issued to all employees informing them the referring physician is required to complete VA Forms 10-2649A and 10-2649B on all inter-facility transfers from NF/SGVHS medical centers and outpatient clinics with ED's or Urgent Care Clinics to non-VHA facilities or other VHA facilities.
2. A memorandum from the COS was issued to all clinical services/sections informing them of the requirement described in item #1 above.
3. Regular reviews of inter-facility transfer forms are completed by HIMS and reported to the Chief, Quality Management Service. The Chief, Quality Management Service, conducts further review to identify the responsible clinical service/section and physician, and reports specific findings to the COS for appropriate follow-up.
4. An inter-facility transfer checklist was created for use by nursing personnel reminding referring physicians of related requirements. The above actions have been implemented and data collection began 6/3/10.

Recommendation 11. We recommended that the VISN Director ensure that the System Director requires that FPPE, OPPE, and provider profiles are in compliance with VHA requirements.

Concur

Training sessions sponsored by VISN 8 were conducted the week of June 7th. All non-compliant services were represented and process

changes were implemented. Folder reviews during external reviews noted improvement and JC was very complimentary of our practice. Recommend closure of this item.

Recommendation 12. We recommended that the VISN Director ensure that the System Director requires that designated employees maintain current life support certification.

Concur

All services will identify staff required to have BLS or ACLS certification. Compliance will be monitored by the ACLS Coordinator/Simulation Lab Coordinator and reported to the Emergency Effectiveness Committee quarterly. Expected completion date is September 1, 2010.

Recommendation 13. We recommended that the VISN Director ensure that the System Director requires that clinicians consistently document all required influenza vaccine elements.

Concur

The Vaccination/Skin Test Template has been revised in the long term care setting to include all required elements. Monitoring will take place during the "Influenza Season" to ensure all fields are completed. Recommend closure of this item.

OIG Contact and Staff Acknowledgments

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