Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-01192-63

Combined Assessment Program Review of the West Palm Beach VA Medical Center West Palm Beach, Florida

January 18, 2011

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 crime awareness briefings 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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Glossary

ACLS	Advanced Cardiac Life Support
AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CLC	community living center
COC	coordination of care
CT	computed tomography
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	West Palm Beach VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
MH	mental health
MR	magnetic resonance
MRI	magnetic resonance imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
NCPS	National Center for Patient Safety
NFPA	National Fire Protection Association
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PPE	personal protective equipment
QM	quality management
RME	reusable medical equipment
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, FL

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 20, 2010.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Physician Credentialing and Privileging
- Reusable Medical Equipment
- Suicide Prevention Safety Plans

Recommendations: We made recommendations in the following four activities:

Magnetic Resonance Imaging Safety: Security of the "mobile" magnetic resonance imaging (MRI) unit should be strengthened, and access to the Radiology Service MRI suite needs to be restricted. Equipment used in MRI areas should be labeled as safe or unsafe, and the MRI compatible ventilator should be properly cleaned and maintained. Staff should comply with local policy and the manufacturer's guidelines when using the ferromagnetic detector, and emergency code drills should be conducted in MRI areas.

Environment of Care: Nursing Service should be consistently represented at environment of care rounds, and fire drills need to be conducted in accordance with National Fire Protection Association requirements. Appropriate staff should receive required training on the identification of environmental hazards that pose a risk to suicidal patients.

Quality Management: The facility needs to develop a process to track compliance with Advanced Cardiac Life Support training, and the Medical Record Committee needs to monitor the use of the copy and paste functions.

Medication Management: Clinicians should consistently document all required influenza vaccination elements.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

(original signed by Patricia Christ
Deputy Assistant Inspector General for
Healthcare Inspections for:)

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

Objectives and Scope

Objectives

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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 selected 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 facility operations for FY 2009 and FY 2010 through September 20, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida,* Report No. 08-01331-32, December 2, 2008). The facility had corrected all findings.

During this review, we also presented crime awareness briefings to 192 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.

Results

Review Activities With Recommendations

MRI Safety

The purpose of this review was to evaluate whether the facility 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 both the "mobile" MRI unit (located in a permanent trailer) and the MRI area in Radiology Service. We examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the facility had developed adequate safety policies and had conducted a risk assessment of the environment, as required by JC.

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

We reviewed the medical records of 10 patients who had received an MRI for evidence of appropriate screening. All 10 patients had been appropriately screened prior to their MRI, and the signed screening forms were scanned into their medical records. Contrast media was used for 5 of the 10 MRIs; however, since none of the 5 patients were

considered high risk, signed informed consent prior to the procedure was not required.

We reviewed the training records of 6 Radiology Service personnel and 10 support personnel who had access to MRI Zones III and IV[1] for evidence of annual MRI safety training. We found that Radiology Service personnel received appropriate training. Support personnel received only the MRI safety training covered in annual mandatory training required for all facility staff. Police staff received MRI safety training for the first time just prior to our visit. Facility managers told us that members of emergency code teams would receive MRI safety training. Since all required staff had at least received the MRI safety training contained in the annual mandatory training module by the time we left site, we made no recommendation for this finding. However, we identified the following conditions that needed improvement.

Safety. American College of Radiology guidelines require physical barriers to prevent unauthorized or uncontrolled access to Zones III and IV. We found that security of the "mobile" MRI unit, located in a trailer in the parking deck area adjacent to the facility, needed to be strengthened. Technicians are usually alone in the unlocked trailer with a patient. Unauthorized access to Zone IV could occur when the technician is assisting the patient in the magnet room.

Equipment kept in the MRI area was not clearly marked "MR Safe," "MR Conditional," or "MR Unsafe," posing a risk that unsafe equipment could inadvertently be introduced into the magnet room. We also found that the MRI compatible patient ventilator contained contaminated sterile supplies, used patient medications, unlocked medication/supply drawers, and "MR Unsafe" metal instruments. Although the ventilator belonged to MRI, it was used for other procedures and was not properly cleaned and maintained.

The configuration of the MRI suite in Radiology Service was inconsistent with American College of Radiology guidance. Zones II and III were combined and shared with CT. Access to Zone III was not physically restricted to only trained MRI staff and screened MRI patients, as required. A curtain was

[1] Zone III is adjacent to the entrance to the magnet room (Zone IV). Access to both zones should be limited to screened patients and MRI staff. There should be physical barriers to prevent unauthorized access to these areas.

the only barrier between patients waiting for a CT scan and the entrance to the MRI magnet room (Zone IV).

We also observed that MRI staff did not comply with their local MRI safety policy or the manufacturer's guidelines for use of the ferromagnetic detector. Although local policy requires staff to remove certain items worn on their person before entering the magnet room and restricts anyone from entering the magnet room if the Ferralert® alarm has sounded, we observed staff entering while the alarm sounded. This condition was also identified in the risk assessment conducted in November 2009.

With the exception of fire drills, emergency code drills (for medical, behavioral, and other types of emergencies) were not conducted in MRI areas.

Recommendations

1. We recommended that security of the "mobile" MRI unit be strengthened.

2. We recommended that equipment used in MRI areas be properly labeled as safe or unsafe and that the MRI compatible ventilator be properly cleaned and maintained after use to ensure that unsafe supplies are not left with the equipment.

3. We recommended that a physical barrier be placed in the Radiology Service MRI suite to prevent unauthorized or accidental entry to Zones III and IV.

4. We recommended that MRI staff comply with local policy and the manufacturer's guidelines regarding use of the ferromagnetic detector.

5. We recommended that emergency code drills be conducted in MRI areas.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, NCPS, OSHA, NFPA, and JC standards.

We inspected the dialysis unit, the locked inpatient MH unit, two CLC units, the hospice unit, the intensive care unit, the emergency department, an inpatient medical unit, the telemetry unit, the dental clinic, three primary care/specialty

clinics, and the post-anesthesia care unit and found that the facility maintained a generally clean and safe environment.

The IC program appropriately aggregated and analyzed hand hygiene data for PI. In addition, PI data was consistently reported to the IC Committee when trends or educational needs that required follow-up were identified. We determined that all selected employees from nursing, Radiology Service, and the bronchoscopy suite had received annual N95[2] fit testing for FY 2010, as required by OSHA. In addition, 27 (87 percent) of 31 selected employees from nursing, medicine, audiology and speech pathology, and Environmental Management Services had completed annual bloodborne pathogens training for FY 2009, as required by OSHA.

The NFPA requires that oxygen tanks be properly secured and stored. We found an unsecured oxygen tank in the isolation room of the post-anesthesia care unit. Managers took immediate action to remove and properly secure the oxygen tank in a storage room. In addition, we found three unattended and unsecured carts stocked with dialysis chemicals on the dialysis unit. While we were onsite, managers removed the carts and placed them inside a storage room. Since these conditions were corrected while we were onsite, we made no recommendations for these findings. However, we identified the following conditions that needed improvement.

Environmental Rounds. VHA policy[3] requires that weekly EOC rounds led by the Director or Associate Director include participation by managers in nursing, building management, engineering, and safety; representatives from patient safety and IC; and others, as required. We reviewed attendance records for EOC rounds conducted during the 2nd and 3rd quarters of FY 2010 and found that Nursing Service was not consistently represented.

Fire and Life Safety. The NFPA requires that fire drills be conducted once per shift per quarter in each building defined as health care occupancy. We reviewed fire drill records for the 4th quarter of FY 2009 and for the 1st, 2nd, and

[2] A disposable particulate respirator that has the ability to filter out 95 percent of particles greater than 0.3 microns in diameter.
[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

3rd quarters of FY 2010 and found that fire drills were not consistently conducted on all shifts.

Training. VHA policy[4] requires employees of locked 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 for FY 2009 and found that only 5 (33 percent) of 15 selected employees from the locked inpatient MH unit and members of the Multidisciplinary Safety Inspection Team had documentation showing completion of required initial or annual training.

Recommendations

6. We recommended that representatives from Nursing Service attend EOC rounds consistently, as required.

7. We recommended that fire drills be conducted in accordance with NFPA requirements.

8. We recommended that locked inpatient MH unit employees and members of the Multidisciplinary Safety Inspection Team receive required training on environmental hazards that represent a threat to suicidal patients.

QM

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of patient care and whether senior managers actively supported the program's activities. We interviewed the facility's Director, the Chief of Staff, and selected QM staff. We evaluated plans, policies, PI data, and other relevant documents.

The QM program was generally effective in providing oversight of the facility's quality of care, and senior managers supported the program through participation in and evaluation of PI initiatives and through the allocation of resources to the program. However, we identified the following QM areas that needed improvement.

Life Support Training. VHA policy[5] requires that all clinically active staff have life support education and that a system is in place to monitor compliance with ACLS and Basic Life

[4] Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.
[5] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advance Life Support (ACLS) Training for Staff,* February 6, 2008.

Support training or certification. The centralized monitoring system did not adequately track certification requirements for all staff designated to have this training.

Medical Record Review. VHA policy[6] requires medical record review to include the use of the copy and paste functions in the electronic medical record. We reviewed January to August 2010 Medical Record Committee minutes and found no documentation of monitoring results on the use of the copy and paste functions.

Recommendations

9. We recommended that the facility develop a process to accurately track compliance with life support training.

10. We recommended that the Medical Record Committee monitor the use of the copy and paste functions.

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 facility complied with local criteria governing the maintenance of chronic renal disease patients who receive ESAs.[7] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. A fee basis provider regulated one patient's ESA, and the primary care provider's progress note reflected the laboratory results and the actions taken. Also, a qualified pharmacist is available 24 hours a day, 7 days a week. However, we identified the following area that needed improvement.

CLC Influenza Vaccinations. VHA[8] requires that several items be documented for each influenza vaccine given, including the route, site, and date of administration. We reviewed the medical records of six CLC residents for vaccine documentation. Medical record documentation for only one of the six residents contained all the required elements.

Recommendation

11. We recommended that clinicians consistently document all required influenza vaccine elements.

[6] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[7] Drugs that stimulate the bone marrow to make red blood cells and are used to treat anemia.
[8] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.

Review Activities Without Recommendations

COC

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[9] requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's acute inpatient units or the emergency department to another facility. Clinicians generally documented the required elements. However, none of the 10 records contained the required AD elements in the transfer documentation. The facility reported that in June 2010, it modified the inter-facility transfer template to address the AD elements. While we were onsite, we reviewed the transfer documentation for 10 additional patients who had been transferred since June 2010. We determined that AD elements were included in the transfer documentation for all 10 patients. Therefore, we made no recommendation for this finding.

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 10 discharged patients and determined that clinicians had documented all the required elements. In addition, we found that follow-up appointments occurred within the timeframes specified and that patients received a copy of the discharge instructions. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of providers, we reviewed selected VHA required

[9] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
[10] VHA Handbook 1907.01.

elements in C&P files and physician profiles.[11] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. FPPE was appropriately implemented for newly hired providers. Service-specific criteria for OPPE had been developed and approved. We found sufficient performance data to meet current requirements. Clinical Executive Board and Professional Standards Board meeting minutes consistently documented thorough discussions of the providers' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

RME

The purpose of this review was to evaluate whether the facility 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 facility's SPD area is required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

We inspected SPD, hemodialysis, gastrointestinal clinic, and operating room areas. We noted that traffic in the SPD areas was restricted to authorized personnel and that appropriate PPE was donned prior to entering the SPD reprocessing areas, as required. Appropriate infection prevention controls were in place, and the facility had a system in place to track RME should a sterilization failure occur.

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

We reviewed the SOPs for reprocessing for seven pieces of RME. We found that six of the seven SOPs were well developed and consistent with the manufacturers' instructions. While we were onsite, minor changes were made to one SOP to reflect actual practice and be consistent

[11] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

with manufacturers' guidelines. Therefore, we made no recommendation for this finding.

VA[12] requires that airflow be carefully controlled to minimize the movement of microorganisms from dirty areas to clean areas. We found that the air pressure in two areas where scopes are reprocessed—after being decontaminated in another area—were not under positive pressure. Changes were made while we were onsite to correct the air pressure in these areas. Therefore, we made no 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 behavior 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. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[13]

A previous OIG review of suicide prevention programs in VHA facilities[14] 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 10 patients assessed to be at high risk for suicide and found that 9 (90 percent) of the 10 patients had safety plans in place. We found that clinicians had developed the safety plans within a reasonable time after identification of the patients' high-risk status. We made no recommendations.

[12] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[13] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[14] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009;* Report No. 09-00326-223; September 22, 2009.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 19–24, for the full text of the Directors' comments.) We consider recommendations 1, 2, 3, 4 and 11 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[15]		
Type of Organization	Medical center	
Complexity Level	1c	
VISN	8	
CBOCs	Boca Raton, FL Delray Beach, FL Fort Pierce, FL Stuart, FL Okeechobee, FL Vero Beach, FL	
Veteran Population in Catchment Area	177,318	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP[16]**	140	
• **CLC/Nursing Home Care Unit**	120	
• **Other**	N/A	
Medical School Affiliation(s)	University of Miami Columbia Hospital/Palm Beach Centre for Graduate Medical Education Nova Southeastern University, School of Medicine Nova Southeastern University, School of Dentistry	
• **Number of Residents**	38 medicine and 2.5 dental	
	Current FY (through September 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$321.4	$309.5
• **Medical Care Expenditures**	$321	$308.7
Total Medical Care FTE	2,121.93	2,105.51
Workload:		
• **Number of Station Level Unique Patients**	57,699	61,569
• **Inpatient Days of Care:**		
o **Acute Care**	31,490	37,400
o **CLC/Nursing Home Care Unit**	27,653	33,534
Hospital Discharges	5,347	7,176
Total Average Daily Census (including all bed types)	194.5	194.3
Cumulative Occupancy Rate	81.74%	75.62%
Outpatient Visits	639,386	609,301

[15] All data provided by facility management.
[16] Psychosocial Residential Rehabilitation Treatment Program.

Follow-Up on Previous Recommendations			
OIG Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
EOC			
1. Correct the electrical closet and the television and video camera recorder electrical cord conditions on the locked MH unit.	Electronic equipment cord lengths were corrected (less than 12 inches). Staff was educated on equipment safety related to electrical cords and electrical closets. Units are being monitored daily by nurse managers and on a quarterly basis.	Y	N
2. Require the Multidisciplinary Safety Inspection Team to complete a risk assessment and action plan to address the environmental hazards in the room designated for MH patients in the emergency department.	The risk assessment was completed, and all environmental physical improvements were completed in August 2008. Emergency department patients identified as high risk are placed on a 1:1 status to ensure patient and staff safety.	Y	N
3. Require CLC nursing staff to comply with IC guidelines for patients on isolation precautions.	An intensive educational program was developed by the IC and MRSA Coordinator and includes hand hygiene, isolation precautions, and the MRSA initiative. IC monitoring is being conducted through routine data pulls, visual inspections, and internal tracers.	Y	N

OIG Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
4. Require contaminated equipment to be clearly identified and stored separately from clean supplies.	Contaminated equipment was removed from the clean supply room during the CAP review. Re-education was provided to nursing and to Environmental Management Service staff on the importance of isolating clean from dirty supplies and equipment. Monitors are in place and are being conducted during environmental rounds and through internal tracers.	Y	N
5. Maintain the security of confidential patient information.	Staff is initially educated on ensuring patient information confidentiality and computer security during mandatory new employee education. Importance is reinforced through ongoing training.	Y	N
6. Maintain the security of housekeeping closets, housekeeping carts, and cleaning solutions.	Environmental Management Service staff completed additional training on maintaining security of housekeeping closets, carts, and all solutions. Compliance is monitored by supervisors and during environmental rounds and internal tracers.	Y	N
7. Provide privacy for all patients on the chemotherapy unit.	The outpatient chemotherapy unit was evaluated, and additional curtains were added so that each lounger has a privacy screen.		

OIG Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
8. Require staff to conduct and document weekly preventative maintenance inspections of the WanderGuard® system.	Preventative maintenance checks on the WanderGuard® system are completed weekly, and oversight was assigned to an Environmental Management Services supervisor to ensure documentation compliance.	Y	N
QM			
9. Require timely completion of peer reviews and the presentation of trending and analysis data to the Clinical Executive Board, as required by VHA policy.	Peer review reports have been completed and reported to the VISN and are now being reported quarterly to the Clinical Executive Board.	Y	N
10. Require that mechanisms are in place to adequately evaluate adverse events that could potentially require disclosure.	The tracking system for Patient Incident Worksheets has been reviewed and improved to identify the timeline involved and all actions taken. A clinical disclosure template has been added to the institutional disclosure template currently in use. Patient Incident Worksheets are reviewed by the Chief of Staff to evaluate the need for disclosure.	Y	N
Pharmacy Operations			
11. Require that all controlled substance inspectors complete appropriate training and competency reviews and that the results are documented.	An annual process has been implemented for all controlled substance inspectors to complete the annual training in the month of September to ensure compliance for the upcoming year.	Y	N

OIG Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
12. Require that clinical pharmacists complete monthly polypharmacy reviews on all CLC patients, as required by the JC.	The pharmacy has instituted a weekly polypharmacy chart review action that will identify all patients due for a polypharmacy review. Pharmacy monitors the process and reports to the Medication Use Committee monthly.	Y	N

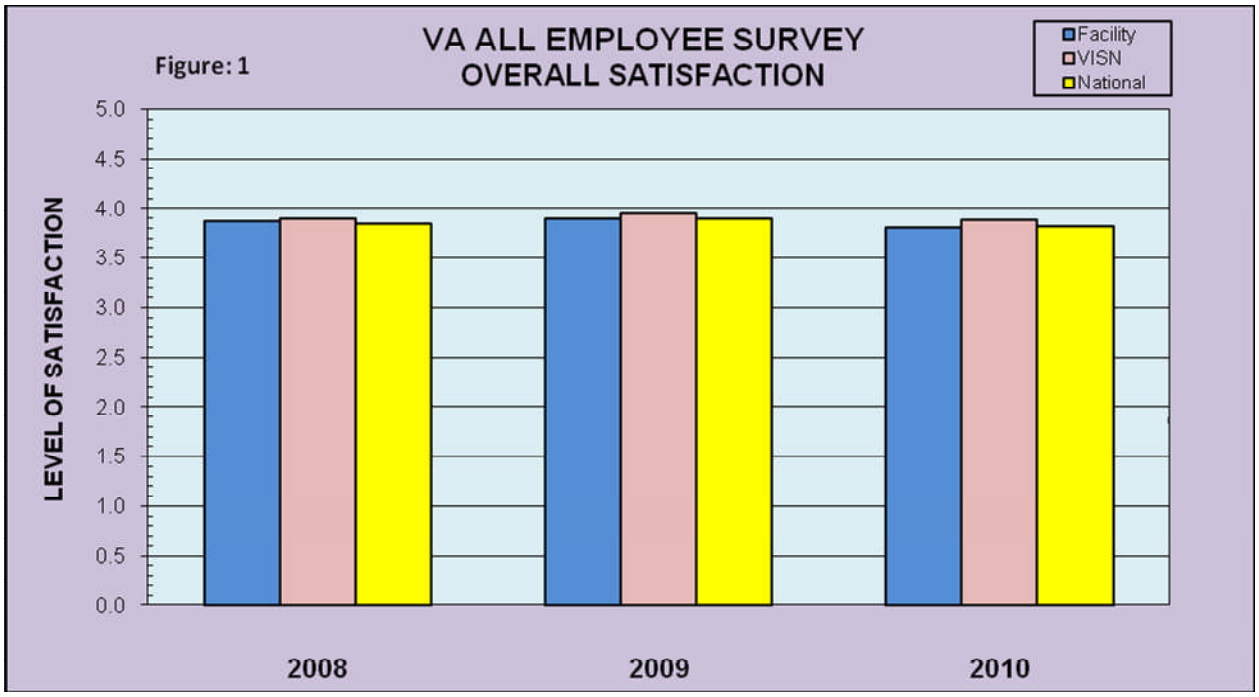
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows facility, VISN, and VHA calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall inpatient and outpatient satisfaction scores and targets for the 1st and 2nd quarters of FY 2010.

Table 1

	FY 2009		FY 2010 (inpatient target = 64; outpatient target = 56)			
	Inpatient Score	Outpatient Score	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	70.29	50.75	68.9	65.4	60.7	59.2
VISN	67.18	57.38	65.8	68.3	58.1	56.8
VHA	65.01	52.87	63.3	63.9	54.7	55.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[17] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	13.55	8.34	13.37	20.02	16.72	15.24
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[17] Congestive heart failure (CHF) is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 20, 2010

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

Subject: **CAP Review of the West Palm Beach VA Medical Center, West Palm Beach, FL**

To: Director, St. Petersburg Healthcare Inspections Division (54SP)

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

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida.

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

(original signed by:)

Nevin M. Weaver, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 20, 2010

From: Director, West Palm Beach VA Medical Center (548/00)

Subject: **CAP Review of the West Palm Beach VA Medical Center, West Palm Beach, FL**

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

1. We thank you for allowing us the opportunity to review and respond to the subject report.

2. We concur with the conclusions and recommendations presented by the Office of the Inspector General. We present you with the plans of action designed to correct those areas for which recommendations were provided.

(original signed by:)
Charleen R. Szabo, 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 security of the "mobile" MRI unit be strengthened.

Concur

Completed: September 27, 2010

Before the OIG exit briefing, a panic button was installed underneath the desk in the MRI "mobile" unit. This panic button has been tested and verified operational by VA Police. In case of emergency, the MRI Technologist pulls the handle and VA police respond to the area immediately. Staff has been educated in the use of the panic button. The MRI "mobile" unit door now is locked per policy at all times and environmental rounds were conducted on December 13, 2010, by QM and the MRI Safety Officer, validating the door was locked. An "MRI Safe" (green color-coded) sticker was placed on the MRI mobile unit stretcher and all other MRI compatible equipment on October 4, 2010. Environmental rounds conducted on December 13, 2010, by QM and the MRI Safety Officer validated the stretcher had the sticker in place and was in the designated safe area.

Recommendation 2. We recommended that equipment used in MRI areas be properly labeled as safe or unsafe and that the MRI compatible ventilator be properly cleaned and maintained after use to ensure that unsafe supplies are not left with the equipment.

Concur

Completed: December 14, 2010

All equipment in MRI Mobile and MRI Suite 1B344 has been labeled with color coded "MRI Safe" and "MRI Unsafe" stickers (Red=Unsafe and Green=Safe) by the MRI Safety Officer. An SOP was developed on December 12, 2010, by Anesthesia, with a Memo of Understanding between Imaging and Anesthesia to ensure the anesthesia cart is kept in the MRI suite, and is cleaned and maintained after use. A monthly report is now required as a standing agenda item for MRI meetings to track and trend anesthesia cart maintenance compliance in the minutes. Issues identified during cart use will have corrective actions implemented and followed by Anesthesia to ensure future compliance.

Recommendation 3. We recommended that a physical barrier be placed in the Radiology Service MRI suite to prevent unauthorized or accidental entry to Zones III and IV.

Concur

Completed: December 8, 2010

Before the OIG exit briefing, a keypad lock was installed on the double door entrance to the MRI Suite 1B-344 to restrict access. Engineering completed the MRI reconfiguration on December 8, 2010, when a wall was installed to separate the CT scan screening area from MRI. A curtain was placed in Zone II for patient privacy during the screening process. The camera was repositioned in the MRI Suite to ensure security and safety of patients and staff.

Recommendation 4. We recommended that MRI staff comply with local policy and the manufacturer's guidelines regarding use of the ferromagnetic detector.

Concur

Completed: December 15, 2010

The MRI Safety Officer revised MRI Safety Policy based on Manufacturer's Guidelines of the Ferralert®, and all staff are following these guidelines. MRI technologists have been trained by the MRI Safety Officer on the proper use of the Ferralert®. The Ferralert® was re-positioned to ensure it is used appropriately. If the yellow light/alarm goes off, the MRI Technician is to investigate and identify ferromagnetic objects. The patient is pre-screened in a private room before entering the Ferralert®.

Recommendation 5. We recommended that emergency code drills be conducted in MRI areas.

Concur

Completed: October 25, 2010

Emergency code drills (Code Blue & Code Green) were conducted on October 25, 2010, and Code Green drills were conducted on December 15, 2010, by the MRI Safety Officer, in collaboration with Education Service. Emergency code drills will be conducted quarterly. Code Blue drills will be reported and documented in the minutes of the CRC Committee, and Code Green drills will be reported and documented in the minutes of the Disturbed Behavior Committee to ensure compliance.

Recommendation 6. We recommended that representatives from Nursing Service attend EOC rounds consistently, as required.

Concur

Completed: September 9, 2010

Nursing Service assigned a registered nurse representative, and two additional alternate staff members to ensure coverage, to participate in the EOC rounds. EOC attendance sheets will support consistent participation.

Recommendation 7. We recommended that fire drills be conducted in accordance with NFPA requirements.

Concur

Completed: October 28, 2010

Fire drills are being conducted once per shift per quarter in each building defined as healthcare occupancy. The CLC had drills completed on the October 28, 2010, day shift, the November 15 evening shift, and one is scheduled for the December 23 night shift to complete the FY11 Qtr 1 schedule.

Recommendation 8. We recommended that locked inpatient MH unit employees and members of the Multidisciplinary Safety Inspection Team receive required training on environmental hazards that represent a threat to suicidal patients.

Concur

Target date for completion: December 31, 2010

Mental Health and Nursing identified clinical staff that permanently work in Mental Health areas as well as those that respond to Code Blue, Rapid Response, and Code Green for training. Currently all identified key staff, except two individuals, have completed the training. Additionally, the decision was made to require all clinical staff to complete this training and it has been added to the Learning Management System (LMS) to ensure accurate tracking and annual compliance, to be completed by December 31, 2010, and then annually. As new staff come on board Nursing and MH will notify Education so that those individuals have the required training entered into LMS. Both MH and Nursing will be given a monthly report to verify compliance.

Recommendation 9. We recommended that the facility develop a process to accurately track compliance with life support training.

Concur

Completed: October 25, 2010

At the time of the OIG survey, individual services were required to track ACLS compliance. To simplify the process and improve compliance tracking and reporting, the decision was made that clinical staff that required ACLS training would be identified and Education has entered ACLS training as a mandatory requirement in LMS, based on their bi-annual renewal date. A deficiency report will be generated by Education and reported to the services monthly and CEB quarterly. As new staff are hired, Credentialing and Nursing will identify ACLS needs and report to Education so LMS can be maintained.

Recommendation 10. We recommended that the Medical Record Committee monitor the use of the copy and paste functions.

Concur

Completed: November 4, 2010

"Copy and Paste" was one of the elements in the existing pertinence review tool submitted by all clinical services. Reporting on "Cutting and Paste" has been added as a standing Medical Records Committee (MRC) agenda item to capture discussion in the minutes. Based on OIG recommendations during the survey, FY10 "Copy and Paste" data previously reported was analyzed and reported to MRC November 4, 2010.

Recommendation 11. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Completed: October 29, 2010

Employee education was provided to all nurses and nurses signed a document to verify that they understood expectations for documentation requirements for Influenza Vaccines in the Bar Coded Medication Administration (BCMA) system. CLC audits were conducted on 72 patients by Nurse Managers in collaboration with the BCMA Coordinator. The audit reflected 100 percent compliance for the month of October, (seasonal month for Influenza vaccines) validating that influenza vaccine education provided by the CLC Clinical Nurse Specialist and the BCMA Coordinator was effective.

Future monitoring will be conducted quarterly and non-compliance will be addressed through re-education tracked by the CLC Clinical Nurse Specialist and the CLC Nurse Managers. Quarterly reports will be submitted to the Nurse Practice Council to track compliance.

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