Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01099-247

Combined Assessment Program Review of the Miami VA Healthcare System Miami, Florida

August 11, 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

ARB	Accident Review Board
C&P	credentialing and privileging
CAP	Combined Assessment Program
CPR	cardiopulmonary resuscitation
EN	enteral nutrition
EOC	environment of care
facility	Miami VA Healthcare System
FY	fiscal year
ILSM	interim life safety measures
JC	Joint Commission
LSC	Life Safety Code
MH	mental health
OIG	Office of Inspector General
OR	operating room
OSHA	Occupational Safety and Health Administration
PI	performance improvement
QM	quality management
RME	reusable medical equipment
RN	registered nurse
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Miami VA Healthcare System, Miami, 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 April 11, 2011.

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

- Coordination of Care
- Enteral Nutrition Safety
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishment was a significant reduction in central line infections.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Ensure all Life Safety Code deficiencies are assessed, interim life safety measure plans are developed as needed, and staff fire safety education is provided. Correct cleanliness deficiencies, and store clean and dirty supplies separately. Require that annual bloodborne pathogens training and respirator fit testing are completed and that unattended computers are locked.

Reusable Medical Equipment: Clean equipment according to manufacturers' instructions, and ensure standard operating procedures are consistent with those instructions. Complete annual competency validations for employees who flash sterilize. Ensure appropriate emergency eyewash stations are located in areas where chemicals are used and are tested weekly. Monitor and appropriately maintain airflow in reprocessing areas. Ensure sterilizers undergo preventive maintenance. Report specific reusable medical equipment elements quarterly to an executive-level committee.

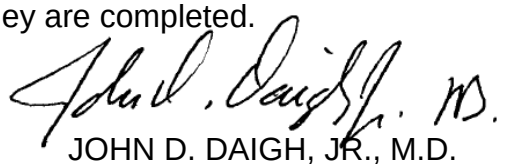
Quality Management: Ensure drug allergy assessments are documented prior to moderate sedation, and monitor compliance. Require resuscitation event elements to be collected and the Cardiopulmonary Resuscitation Committee to review all resuscitation event evaluations. Monitor use of the copy and paste functions.

Registered Nurse Competencies: Ensure competency validation methods are documented for required skills.

Management of Workplace Violence: Ensure all violent incidents involving employee victims are discussed at the Accident Review Board.

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.



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

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 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

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 nine activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RME
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through April 11, 2011, 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 Miami VA Healthcare System, Miami, Florida,* Report No. 08-00777-200, September 10, 2008). (See Appendix B for further details). We identified a repeat finding in EOC.

During this review, we also presented crime awareness briefings to 223 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.

Reported Accomplishment

Reduction in Central Line Infections

A central venous catheter, commonly referred to as a central line, is a catheter placed into a large vein in the neck, chest, or groin to administer fluids or medications.[1] The Central Line Bundle is a group of evidence-based interventions recommended by the Institute for Healthcare Improvement that are proven to result in better outcomes.

Despite the facility's strict adherence to the Central Line Bundle, the incidence of central line associated bloodstream infections in the intensive care units remained unacceptably elevated in FYs 2007 and 2008. In FY 2009, a multidisciplinary team analyzed the problem and then designed and implemented a second bundle of interventions aimed at improving central line care and blood collection techniques. These interventions resulted in an 80 percent reduction in central line infections from FY 2009 to FY 2010, with no central line infections for 11 consecutive months.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

[1] Central lines disrupt the integrity of the skin, making infection with bacteria and/or fungi possible. Infection may spread to the bloodstream, and blood circulation changes and organ dysfunction may ensue, possibly leading to death.

We inspected the medicine, surgical intensive care, extended care, spinal cord injury, locked inpatient MH, and community living center units. We also inspected the emergency department; the same day surgery and post-anesthesia areas; and the cardiology, oncology, dialysis, and dental outpatient clinics. We identified the following conditions that needed improvement.

Fire and Life Safety. National Fire Protection Association LSC standards require that doors be present to protect corridor openings and to resist and compartmentalize the passage of smoke. The JC requires that an ILSM plan be implemented when LSC deficiencies cannot be immediately corrected and that hospitals train employees to compensate for impaired structural or compartmental fire safety features.

We found five patient rooms without doors on the locked inpatient MH unit. The doors were removed in 2010 because of damaged hinges, and managers told us that an ILSM plan had not been developed. Additionally, unit managers had not been trained and could not verbalize the fire evacuation plan specific to the unit. While we were onsite, managers completed an ILSM plan, contracted with a vendor to replace the doors, and began installing doorstops to prevent future damage.

The JC requires that fire alarm systems, including visual and auditory alarms, be tested annually. We found that while the fire alarm system had been inspected in 2010, the vendor reported that 32 audio/visual alarms could not be tested. Staff told us that the alarms were inoperable due to a circuit malfunction and that an ILSM plan was not in place while the audio/visual alarms were inoperable. The fire alarm vendor returned 17 days later to test the remaining alarms, which were then operable.

The JC also requires that corridors be clear of obstructions in the event that emergency evacuation is necessary. In the medicine unit, the emergency department, and the OR temporary trailer, we found the egress to a fire exit obstructed. Facility managers immediately removed the obstructions from each area.

General Cleanliness. The JC requires that areas used by patients be clean. During our inspection of patient care areas, we noted general conditions of uncleanliness needing improvement. In patient rooms, common areas, and

housekeeping and utility closets, we found dirt and debris on floors, along baseboards, and in corners. Additionally, dust accumulation was visible on numerous air vents.

Infection Control. OSHA requires that employees with occupational exposure risk receive annual training on the OSHA Bloodborne Pathogens Rule. We reviewed 10 clinical employee and 21 Environmental Management Service employee training records. Only 1 of the 10 clinical employees and only 1 of the 21 Environmental Management Service employees did not have documentation of training. However, we noted that eight employees completed the training the week prior to our onsite visit and that training was overdue by 1 week to 3.5 years.

OSHA also requires that facilities using N95 respirators fit test designated employees annually. We reviewed the records of 20 employees and found that 7 employees did not have the required annual fit testing.

Clean/Dirty Storage. The JC requires that clean and dirty supplies be stored separately. We found housekeeping supplies, chemicals, and used gloves and rags stored in the clean linen supply closet on the dialysis unit. In addition, we found an exposed clean linen supply in a patient care area in the emergency department. Facility managers immediately separated the clean and dirty supplies.

Patient Privacy. The Health Insurance Portability and Accountability Act requires confidential patient information to be secured. We found eight unattended computers in patient care areas displaying patient information. This was a repeat finding from our previous CAP review.

Recommendations

1. We recommended that processes be strengthened to ensure that all LSC deficiencies are assessed, ILSM plans are developed as needed, and appropriate staff education is provided to ensure fire safety.

2. We recommended that a comprehensive EOC inspection of the facility be conducted and that appropriate actions be taken to correct cleanliness deficiencies.

3. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately.

5. We recommended that processes be strengthened to ensure that computers are locked when not attended.

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 a safe environment. The facility's reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and the JC standards.

We inspected the SPD, gastrointestinal unit, OR, hemodialysis, and cardiac catheterization reprocessing areas. We found that all areas were clean and that clean and dirty equipment were separated. In addition, we found that appropriate monitors for biological and chemical monitoring were in place and that SPD staff competencies and training were completed.

VA requires that traffic in the SPD areas be restricted to authorized personnel and that appropriate personal protective equipment be donned prior to entering SPD reprocessing areas.[2] We observed a Biomedical Engineering employee enter the decontamination area without proper personal protective equipment. SPD staff instructed the employee to don the appropriate personal protective equipment, and facility managers assured us the employee received additional education. Therefore, we made no recommendation for this finding. However, we identified the following areas that needed improvement.

RME and Case Cart Cleaning Processes. VHA requires that staff clean RME according to manufacturers' instructions.[3] We observed the cleaning of three pieces of RME that required low-level disinfection and determined that staff appropriately followed manufacturers' instructions. We also observed the reprocessing of eight pieces of RME that required high-level disinfection or sterilization. SPD staff did

[2] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.
[3] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

not follow the manufacturers' instructions for four of the eight pieces of RME.

Additionally, we found that the surgical case cart washer had been out of service since November 2010. While we were onsite, SPD staff demonstrated the interim process for cleaning the surgical case cart. The demonstration did not include letting the detergent stand for 10 minutes, as required by the detergent manufacturer's instructions, or cleaning the surgical case cart wheels, as required by local process.

SOPs. VHA requires facilities to establish device-specific SOPs for reprocessing RME in accordance with the manufacturers' instructions.[4] We reviewed the SOPs and manufacturers' instructions for six pieces of RME. We found that the SOPs for three of the six pieces of RME were not fully consistent with the manufacturers' instructions.

Flash Sterilization Competencies. VHA requires annual competency validation for staff who flash sterilize RME.[5] We reviewed the competency folders for 10 OR employees and found that none had current competency validations for flash sterilization.

Eyewash Station Appropriateness and Testing. OSHA requires that an eyewash station be available for immediate use in areas where employees could be exposed to injurious, corrosive chemicals. The American National Standards Institute requires that eyewash stations be checked weekly to assure proper functioning. We noted that there was a portable eyewash station within the immediate vicinity of the OR in an area where chemicals were used. However, based on the volume of water it could contain, this portable eyewash station did not meet the requirements for 15-minute eye irrigation. In addition, we found that the eyewash station in the SPD decontamination area was not checked weekly.

Air Quality. VA requires that airflow be carefully controlled to minimize the movement of microorganisms from areas where equipment is cleaned to areas where clean equipment is stored.[6] Local policy requires monthly monitoring of the

[4] VHA Directive 2009-031.
[5] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[6] VA Handbook 7176.

airflow in these areas. During tests conducted from March through August 2010, the facility identified that positive air pressures were not maintained in the gastrointestinal unit clean area. However, there was no evidence to show that corrective actions were taken during this 6-month period. In addition, we found that monitoring of airflow was not completed in the reprocessing areas in December 2010.

Sterilizer Preventive Maintenance. VA requires that equipment sterilizers undergo preventive maintenance in accordance with manufacturers' instructions.[7] The facility has an electronic work order system to track and document completed equipment repairs and preventive maintenance. However, an EtO gas sterilizer[8] was not entered into the system when it was placed into service on May 21, 2008. System records show that the sterilizer has undergone repairs; however, since the sterilizer was not set up in the system, the required preventative maintenance was not documented as completed.

Facility Reporting. VHA requires that specific RME elements, including validation of initial and ongoing staff competencies, SOP compliance, infection control monitoring, and risk management activities, be reported quarterly to an executive-level committee.[9] We found that RME reports were not provided to an executive-level committee.

Recommendations

6. We recommended that SPD staff clean RME according to manufacturers' instructions and clean surgical case carts according to detergent manufacturer's instructions and the interim local process.

7. We recommended that SOPs be consistent with manufacturers' instructions.

8. We recommended that managers complete annual competency validations for employees who flash sterilize RME.

[7] VA Handbook 7176.
[8] An EtO gas sterilizer is an automatic device that sterilizes plastic, rubber, metal, or sensitive materials using the anti-bacteriologic agent ethylene oxide.
[9] VHA Directive 2009-004.

9. We recommended that appropriate emergency eyewash stations are located in areas where chemicals are used and are tested weekly to ensure proper functioning.

10. We recommended that airflow in the reprocessing areas be monitored and appropriately maintained.

11. We recommended that processes be strengthened to ensure that sterilizers undergo preventive maintenance in accordance with manufacturers' instructions.

12. We recommended that specific RME elements be reported quarterly to an executive-level committee.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Moderate Sedation. VHA requires providers to document a complete history and physical within 30 days of a procedure requiring moderate sedation and to re-evaluate the patient immediately prior to sedation.[10] These evaluations must include a review of drug allergies. We reviewed the medical records of 10 patients who received moderate sedation and found that 2 records did not contain drug allergy assessments.

Resuscitation Event Outcomes. VHA requires that facilities have a CPR Committee that reviews each resuscitation event and that specific elements, such as delays in CPR, be collected and reviewed for trends.[11] We found that while individual events were evaluated, results were not reported to the committee. We also found that data on delays in initiating CPR were not collected.

Medical Record Reviews. VHA requires that medical record reviews include monitoring for inappropriate use of the copy

[10] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[11] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

and paste functions.[12] We found that only Primary Care Service monitored for inappropriate use of the copy and paste functions.

Recommendations

13. We recommended that processes be strengthened to ensure that drug allergy assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

14. We recommended processes be strengthened to ensure that all required resuscitation event elements are collected and that the CPR Committee reviews all resuscitation event evaluations.

15. We recommended that medical record review processes be strengthened to ensure that inappropriate use of the copy and paste functions is monitored.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies and processes, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Methods. The JC requires facilities to specify the assessment methods used (such as test taking, demonstration, or simulation) to determine an individual's competency in required skills. We found that validation methods were not consistently specified in 5 of the 12 competency folders reviewed.

Recommendation

16. We recommended that competency validation methods be documented for required skills.

Management of Workplace Violence

The purpose of this review was to determine whether the facility issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed

[12] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

applicable documents. We identified the following area that needed improvement.

Management of Incident. VHA policy requires that all violent incidents involving employee victims be discussed at the facility's ARB.[13] We reviewed ARB meeting minutes for FY 2010 and for FY 2011 through February 2011 and did not find documentation of discussion of an incident in which a patient assaulted an employee.

Recommendation

17. We recommended that processes be strengthened to ensure that all violent incidents involving employee victims are discussed at the ARB.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed 20 patients' medical records and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no recommendations.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. While conducting the EOC review, we also inspected areas where EN products were stored, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy medications, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology outpatient clinic, and we interviewed employees. We determined that the facility

[13] VHA Handbook 7701.01, *Occupational Safety and Health (OSH) Program Procedures*, August 24, 2010.

safely prepared, transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files and profiles and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

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 17–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[14]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	8	
Community Based Outpatient Clinics	Coral Springs, FL Deerfield Beach, FL Hollywood, FL Homestead, FL Key Largo, FL Key West, FL Miami, FL Sunrise, FL	
Veteran Population in Catchment Area	285,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	444	
• **Community Living Center/Nursing Home Care Unit**	110	
• **Other**	118 domiciliary	
Medical School Affiliation(s)	University of Miami Miller School of Medicine	
• **Number of Residents**	158	
	Current FY (through January 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$416	$425
• **Medical Care Expenditures**	$155	$459
Total Medical Care Full-Time Employee Equivalents	2,627	2,640
Workload:		
• **Number of Station Level Unique Patients**	39,954	54,951
• **Inpatient Days of Care:**		
o **Hospital**	14,778	40,621
o **Psychosocial Residential Rehabilitation Treatment Program**	5,124	6,439
o **Community Living Center/Nursing Home Care Unit**	5,416	31,579
Hospital Discharges	2,301	6,450
Total Average Daily Census (including all bed types)	206	240
Cumulative Occupancy Rate (in percent)	54	57
Outpatient Visits	249,267	730,820

[14] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Reinstitute the PI Council, and implement proposed changes to the Leadership Council to improve the coordination of system-wide PI activities.	The governance framework changed in January 2011. The PI Council was absorbed by the Performance Committee Executive Leadership Board, and PI information is reported directly to them. Local policy has been modified to reflect these changes.	Y	N
2. Fully implement the policy for evaluation and disclosure of adverse events and track compliance with VHA policy.	The disclosure policy and the clinical disclosure note title and template remain active in the computerized medical record. There has been an increase in the use of the clinical disclosure process since 2007. The Chief of Staff and the Preventive Ethics Coordinator provided disclosure refresher education. Disclosure reports are aggregated quarterly and reported to the Medical Executive Committee monthly.	Y	N
EOC			
3. Conduct and document patient monitoring every hour on the locked MH unit in accordance with the risk abatement plan.	Nursing staff conduct and document patient monitoring every hour on the locked MH unit.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
4. Maintain the security of confidential patient information.	The Information Security Officer and Privacy Officer assess patient care areas on a weekly basis through EOC rounds. Reports are sent to area managers, and corrective actions are implemented when opportunities for improvement are identified. Information is reported to the EOC Safety Committee.	N	Y (see pages 4 and 5)

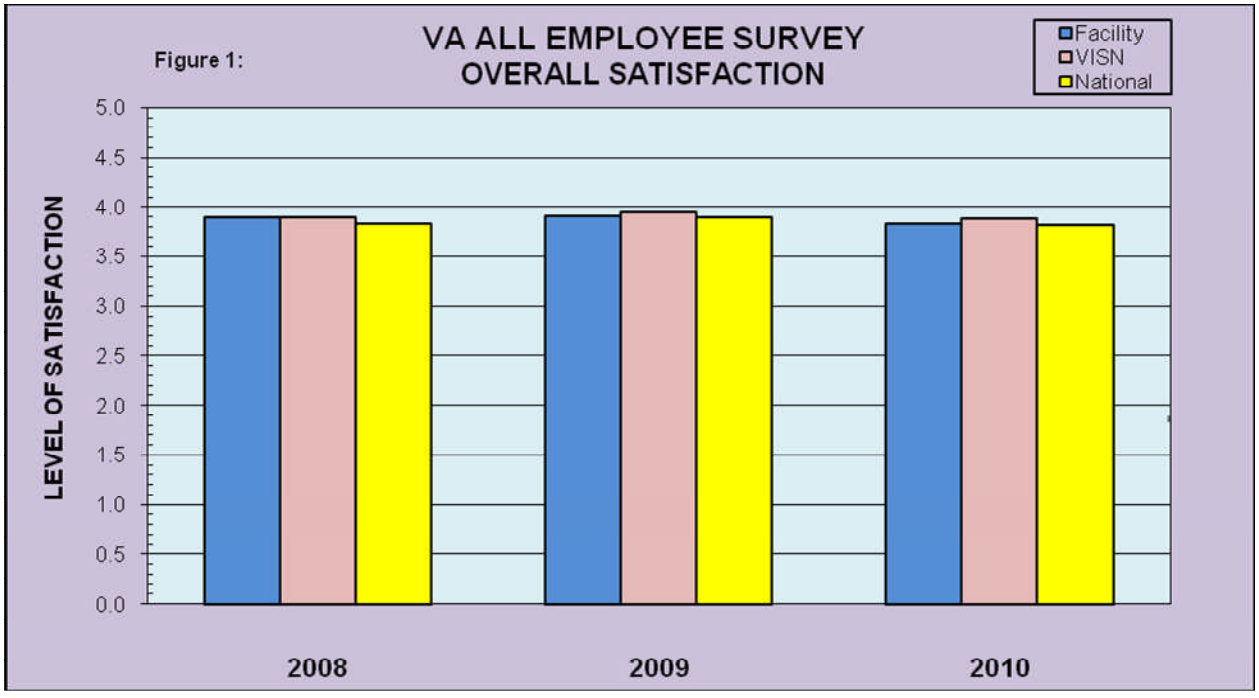
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	59.1	57.1	66.4	63.0	56.3	50.0	54.0	55.0
VISN	65.8	68.3	64.3	65.1	58.1	56.8	56.5	56.4
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

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[15] 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	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	12.70	7.56	14.43	19.97	21.19	16.70
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[15] Congestive heart failure 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 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: June 30, 2011

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

Subject: **CAP Review of the Miami VA Healthcare System, Miami, FL**

To: Associate Director, Bay Pines Healthcare Inspections Division (54SP)

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

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the Miami VA Healthcare System, Miami, Florida.

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

Nevin M. Weaver

Nevin M. Weaver, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 29, 2011

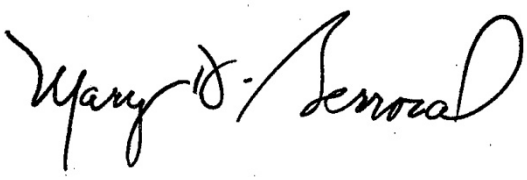
From: Director, Miami VA Healthcare System (546/00)

Subject: **CAP Review of the Miami VA Healthcare System, Miami, 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.



Mary D. Berrocal

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 processes be strengthened to ensure that all LSC deficiencies are assessed, ILSM plans are developed as needed, and appropriate staff education is provided to ensure fire safety.

Concur

Target date for completion: December 31, 2011

The Facilities/Engineering Service and the COTR will design a validation tool to ensure that at the start of any project or construction an assessment is made to determine the need for ILSM. In addition, ILSM assessments will be conducted when any facility deficiency is found during EOC rounds or by any other means. Safety Section and P&A staff will work together to ascertain and implement appropriate ILSM, and post at the entrances of construction sites/areas. A current ILSM inventory will continue to be enforced by the Occupational Health and Safety Specialist and reported to the EOC-Safety Committee on a monthly basis and the Administrative Executive Board on a quarterly basis. Specifically for the Mental Health (MH) unit, the ILSM plan will include the following: (1) ensure free and unobstructed exits (2) no smoking policy enforced (3) enforced the housekeeping procedures to ensure a safe work environment during the project (4) to increase hazard surveillance (5) staff training (6) Increase hazard surveillance by organizational-wide educational programs. Training will be conducted 1 day per month with two sessions during the next 6 months.

Recommendation 2. We recommended that a comprehensive EOC inspection of the facility be conducted and that appropriate actions be taken to correct cleanliness deficiencies.

Concur

Target date for completion: August 1, 2011

During the OIG inspection the vents and debris identified in the patient care areas, common areas, and others were cleaned on the spot. These areas are covered under the daily schedule for sanitation cleaning which includes disinfecting floors by wet mopping; dry mopping, horizontal/ vertical dusting, restroom care, and other duties. Also, there is a separate floor maintenance schedule which includes more intense scrubbing and stripping of floors every 90 days. All vents were cleaned by April 13, 2011. In addition to participation in organizational EOC inspections the EMS Supervisors are now required to perform a minimum of two inspections on a weekly basis. Areas identified as needing more cleaning are followed-up by the supervisor for

completion. An EMS-Floor Care Coordinator has been identified to communicate with nursing service and will perform consistent rounds for the maintenance of floors throughout patient care areas and other critical areas. The Chief, EMS participates in weekly EOC rounds where deficiencies are identified and followed through with supervisors. During these rounds, tracking and trending analysis on sanitation issues are reported through the EOC-Safety Committee.

Recommendation 3. We recommended that annual blood borne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: (a) September 28, 2011; (b) January 2012

The Employee Education Office will produce quarterly compliance reports for annual blood borne pathogen training and submit those to the respective Service Chiefs with a copy to Infection Control and to the Executive Leadership as appropriate.

In order to improve the current process for N95 respirator fit testing, the following initiatives are being implemented: (1) categorize the fit testing program by service/binder (2) update the employee list by service with current employee information and fit testing date and (3) consolidate the respiratory fit testing program with other required employee annual health checks, i.e. PPD in collaboration with Safety, Human Resources, Infection Control, and IRMS to have a systematic process for these programs.

Recommendation 4. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately.

Concur

Target date for completion: September 28, 2011.

Monitoring of separation of clean and dirty equipment will be incorporated into EOC rounds and RME tracers as of August 29, 2011 and reinforced with EOC rounds members. Documentation of findings will be added to the EOC rounds check sheet. Education and corrective interventions are provided on-site as deficiencies are identified. Education on separation of clean and dirty has been scheduled in conjunction with blood borne pathogen training to be completed by September 28, 2011.

Recommendation 5. We recommended that processes be strengthened to ensure that computers are locked when not attended.

Concur

Target date for completion: Completed July 5, 2011. Recommend closure.

The training program on Information Security has been reinforced by offering bi-weekly classes to new employees. As of today 97 percent of all MVAHS employees have been trained. In addition, Information Security Officers (ISOs) will now participate in EOC rounds to identify security/confidentiality issues among employees with their personal computers. Some corrective measures include having ISOs implementing corrective measures during the rounds to address any discrepancies. Also, there was a security feature added to all personal computers where they are locked automatically every 15 minutes. Additionally, a violation notice and computer access termination process has been instituted. When information security violations are identified the ISO will issue a hardcopy Information Security Violations Notice to the employee and their supervisor. After the second violation has been identified computer access will be terminated. Access may only be regained after additional training and Supervisor/Service Chief approval.

Recommendation 6. We recommended that SPD staff clean RME according to manufacturers' instructions and clean surgical case carts according to detergent manufacturer's instructions and interim local process.

Concur

Target date for completion: Training Completed June 28, 2011. Recommend closure.

Miami VA recognizes the importance of strict adherence to manufacturer's guidelines for reprocessing of all RME. A continuous process of education and re-education has been in place and further strengthened with the goal of eliminating any deviation from manufacturer's recommendations, to include minimizing potential human error. If any deviations are identified, a thorough fact-finding is conducted and timely appropriate actions/interventions are implemented to promptly address the findings. Miami VA has developed a procedure for cleaning the case carts and all staff has been educated on the process. Of the 20 people who work in the area in Miami, 19 have been trained and 1 is on extended military leave. In addition, Miami has identified savings in SPD budget and will utilize funding to replace the cart washer. We anticipate replacement of the cart washer by February 2012.

Recommendation 7. We recommended that SOPs be consistent with manufacturers' instructions.

Concur

Target date for completion: September 16, 2011

The current established process of the review of the SOP documentation has been strengthened to ensure that all SOPs adhere strictly to manufacturer's recommendations. The cited SOPs were revised verbatim to the manufacturer's language and are currently in the review process. All SOPs will go through the RME Committee for review.

Recommendation 8. We recommended that managers complete annual competency validations for employees who flash sterilize RME.

Concur

Target date for completion: Completed May 31, 2011. Recommend closure.

All staff that performs flash sterilization completed a competency addendum in May 2011.

Recommendation 9. We recommended that appropriate emergency eyewash stations are located in areas where chemicals are used and are tested weekly to ensure proper functioning.

Concur

Target date for completion: Completed. Recommend closure.

In the temporary OR there is a portable eye wash station in use, but based on the volume it did not meet the required 15 minutes of eye irrigation. The Safety Department has increased the number of bottles for eye irrigation to meet with standard requirement of 15 minutes. Eyewash stations are being tested weekly in SPD as recommended. A tracking mechanism has been implemented to document testing.

Recommendation 10. We recommended that airflow in the reprocessing areas be monitored and appropriately maintained.

Concur

Target date for completion: July 30, 2011.

A process of notification of staff in the area any time pressure is out of range will be developed. The area is monitored 24 hrs, 7 days a week by a SIEMENS pressure differential monitor.

In addition the facility is constructing a new reprocessing room (A712) with an expected completion date of September 30, 2011. The new utilities/equipment (new exhaust system, new differential pressure monitors, and the new temperature/relative humidity sensors) will be entered into the Equipment Inventory List and preventive maintenance on this equipment shall be done per manufacturers' specifications.

Recommendation 11. We recommended that processes be strengthened to ensure that sterilizers undergo preventive maintenance in accordance with manufacturers' instructions.

Concur

Target date for completion: Completed April 15, 2011. Recommend closure.

All sterilizers are being serviced in accordance with manufacturer's specification. The electronic equipment record for one of the model 3017 EtO sterilizers, EE# 61602, was not complete. It has been corrected.

Recommendation 12. We recommended that specific RME elements be reported quarterly to an executive-level committee.

Concur

Target date for completion: July 31, 2011

Our process of reporting RME elements to an executive level committee was revised and fully implemented since January 2011. In order to improve the current process a quarterly monitoring of the process has been established by the Medical Executive Board. The MEB will include this specific RME monitor in its report to the PCELB on a quarterly basis.

Recommendation 13. We recommended that processes be strengthened to ensure that drug allergy assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored.

Concur

Target date for completion: August 30, 2011

The Chief of Surgery and Chair of the Operative and Invasive Committee discussed and agreed the "Pre-Invasive Assessment" note template will be adjusted to include allergies. The attending doctors will be inputting the allergy information into the note. We collaborated with Informatics, who are making a tutorial (completed by 7/1/11) to educate the doctors on how to pull the allergies into the note most efficiently. The allergies listed in the patients' chart will automatically be populated into the note. We will also be making copies of this tutorial and post them by the computers as a reminder to include the allergies (with the instructions). The COS will send this tutorial to providers hospital wide. We collaborated with IRMS and submitted a "footprint" request to adjust the template to automatically include the allergies. Expected completion on this is by 8/5/11. A forced field will be added to the template: an area addressing "previous reactions" to past anesthesia either with a "no," or "yes" with an area to explain the reaction/problem. The surgical QM specialist will monitor OR/moderate sedation areas looking at various attending doctors notes monthly for compliance. An update to these process/findings will be discussed at the monthly Operative and Invasive Committee meeting.

Recommendation 14. We recommended processes be strengthened to ensure that all required resuscitation event elements are collected and that the CPR Committee reviews all resuscitation event evaluations.

Concur

Target date for completion: Completed. Recommend closure.

The completion of the Cardiopulmonary Resuscitation Monitoring sheet was strengthened by collaboration between nursing and the QM representative to the CPR Committee. A new process is that the QM representative contacts the person who completed the code monitoring sheet and requests that any missing elements be completed within 7 days. The VISN reporting format was adopted which identifies any delays in initiating CPR through procedure issues. Any outliers are reported monthly to the CPR committee. Under the strengthened process, the Chair of the CPR Committee performs an in depth review of all resuscitation events and reports his findings and recommendations monthly to the CPR Committee.

Recommendation 15. We recommended that medical record review processes be strengthened to ensure that inappropriate use of the copy and paste functions is monitored.

Concur

Target date for completion: October 1, 2011

The following processes to strengthen reporting of copy and paste monitoring are being implemented:

(1) The Coding Section will report inpatient and outpatient copy and paste monitors (including eight defined elements) on an ongoing basis at the Medical Records Committee.

(2) Clinical Services have been asked to incorporate copy and paste monitoring into their service specific reviews and where instances are found of copy and paste they will review the eight defined elements identified.

(3) The facility Copy and Paste Policy was approved and published May 18, 2011.

Recommendation 16. We recommended that competency validation methods be documented for required skills.

Concur

Target date for completion: October 1, 2011

The Nursing Competency forms are being modified to include a column to specifically document (circle) the assessment/validation method being used to assess the

competency/skill. The new forms will be rolled out October 1, 2011 (commencing the new FY proficiency /evaluation cycle). This OIG finding and form modification will be presented to the Nursing Executive Council (NEC) on Wednesday, July 13, 2011.

Recommendation 17. We recommended that processes be strengthened to ensure that all violent incidents involving employee victims are discussed at the ARB.

Concur

Target date for completion: July 29, 2011

MVAHS is in the process of reviewing and implementing a new Accident Review Board (ARB) with a charter/policy to ensure appropriate personnel are members of the ARB. The ARB Committee will meet monthly and report to the Administrative Executive Board (AEB). One of the responsibilities of the ARB is to anonymously discuss all employee accidents/incidents in order to ensure the health and safety of all employees. The ARB will focus on employee's incident/accident and look for causation, proper coding, prevention and, accident/mishap investigation.

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