Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00884-197

Combined Assessment Program Review of the Bay Pines VA Healthcare System Bay Pines, Florida

June 12, 2012

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

CAP	Combined Assessment Program
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Bay Pines VA Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
HPPD	hours per patient day
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, 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 9, 2012.

Review Results: The review covered 11 activities. We made no recommendations in the following activities:

- Colorectal Cancer Screening
- Coordination of Care
- Medication Management
- Point-of-Care Testing

The facility's reported accomplishments included computerizing resuscitative event documentation and reducing the facility's carbon footprint.

Recommendations: We made recommendations in the following seven activities:

Environment of Care: Require Environment of Care Committee minutes to reflect discussion of deficiencies and tracking of items to closure. Ensure all required staff attend rounds. Require the hazardous materials inventory to be current. Conduct and document resident room contraband inspections.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Mental Health Treatment Continuity: Ensure discharged mental health patients receive 7-day post-discharge follow-up. Require discharged mental health patients on the high risk for suicide list to receive follow-up at the required intervals. Initiate and document attempts to follow up with patients who fail to keep their mental health appointments.

Polytrauma: Ensure that interdisciplinary care plans are completed on the template and provided to patients and/or their families and that case management is consistent.

Quality Management: Complete the required form for all newly hired licensed independent practitioners.

Nurse Staffing: Reassess the target nursing hours per patient day to plan for staffing and evaluate the actual staffing provided.

Follow-Up on Respirator Fit Testing: Ensure all designated employees complete annual respirator fit testing, and monitor compliance.

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.
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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 11 activities:

- COC
- CRC Screening
- EOC
- Follow-Up on Respirator Fit Testing
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through April 9, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Bay Pines VA Healthcare System, Bay Pines, Florida,* Report No. 10-02992-83, February 8, 2011). We made a repeat recommendation regarding respirator fit testing.

During this review, we presented crime awareness briefings for 212 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 460 responded. We shared survey results with facility managers.

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 Accomplishments

Resuscitation Event Documentation

During a resuscitation event, clinical staff use a handheld computer to document actions taken as they occur. Once the resuscitation event is over, all information is seamlessly uploaded to the patient's EHR. Using this technology improves documentation of events and provides information important for future treatment.

Time Out Boards

Time out boards have been implemented in areas of the facility where procedures are performed. The boards serve as a tool for clinicians to verify that all required patient information is documented and that the necessary supplies and equipment for the scheduled procedure are available prior to initiation of the procedure. The time out boards are a creative way to enhance patient safety.

Green Initiatives

To improve energy efficiency and reduce the facility's carbon footprint on the environment, numerous initiatives have been implemented. These include co-mingled recycling of paper, glass, and cans; reflective roof coatings; changes in lighting

systems; and a new energy-efficient laundry plant that reduces water consumption. Additionally, solar powered photovoltaic systems are being installed, which will reduce energy consumption by an estimated 2.1 million kilowatts per hour for an annual savings in energy costs of $230,000.

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 and whether the facility's Domiciliary Care for Homeless Veterans Program, general domiciliary, and Substance Abuse RRTP were in compliance with selected MH RRTP requirements.

We inspected the general medical, surgical, acute MH, surgical intensive care, and community living center units; the emergency department; the SCI outpatient clinic; the dental clinic; primary care; and selected MH RRTP units. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for General EOC
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.

	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

EOC Committee Activities. The Joint Commission requires the facility to monitor and analyze EOC issues and to take action on identified deficiencies until resolved. VHA requires the Director or Associate Director to lead weekly EOC rounds.[1] Managers in nursing, building management, engineering, safety, patient safety, and infection control must be included as well as the Information Security Officer and others, as required. We reviewed monthly EOC Committee minutes and determined that they did not sufficiently reflect discussion of identified deficiencies from EOC rounds, progress toward resolution, and tracking of items to closure. Additionally, we reviewed EOC rounds documentation and determined that all required participants or their designees did not consistently participate in EOC rounds.

Environmental Safety. The Joint Commission requires that the facility maintain a written, current inventory of hazardous materials it uses, stores, or generates. The facility's hazardous materials inventory had not been updated for some services since 2008.

MH RRTP Inspections. VHA requires facilities to conduct and document inspections of at least 10 percent of resident rooms weekly for contraband.[2] Additionally, VHA requires daily room inspections for unsecured medications. We found that resident room contraband inspections were not consistently completed or appropriately documented. We also found unsecured prescription ointments, creams, and products in resident rooms on two units.

Recommendations

1. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient discussion, progress toward resolution, and tracking of items to closure.

2. We recommended that processes be strengthened to ensure that all required participants or their designees consistently attend EOC rounds.

[1] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[2] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Program (MH RRTP),* December 22, 2010.

3. We recommended that processes be strengthened to ensure that the facility's hazardous materials inventory is current.

4. We recommended that processes be strengthened to ensure that resident room contraband inspections are consistently conducted and documented and that daily room inspections for unsecured medications are completed.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 9 EHRs, and 103 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[3] None of the patients' EHRs included all required elements of the history and physical examination, such as a history of previous experience with sedation, a review of substance abuse, and an airway assessment.

Recommendation

5. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[3] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
X	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[4] Eight of the 20 patients who were not on the high risk for suicide list did not receive outpatient post-discharge MH follow-up within 7 days.

Follow-Up for High Risk for Suicide Patients. Through its MH performance measures, VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list receive 2 outpatient follow-up evaluations within 14 days of discharge and 2 outpatient follow-up evaluations within 15–30 days from discharge. Three of the 10 patients discharged who were on the high risk for suicide list did not receive MH follow-up at the required intervals.

Contact Attempts. VHA requires documentation of efforts to follow up with patients who do not keep scheduled MH appointments.[5] For 2 of the 11 patients who failed to keep a scheduled MH appointment, we did not find documentation of follow-up attempts.

Recommendations

6. We recommended that processes be strengthened to ensure that discharged MH patients receive 7-day post-discharge follow-up and that compliance is monitored.

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[5] VHA Handbook 1160.01 and VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010.

7. We recommended that processes be strengthened to ensure that discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

8. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance is monitored.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, 10 EHRs of patients receiving outpatient TBI management, and 10 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
X	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a Case Manager assigned and a specific interdisciplinary treatment plan developed.[6] The plan developed by the interdisciplinary team must be provided to the patient and/or his or her family. Additionally, the facility expected staff to use the VHA care plan template. None of the 10 outpatients or their families was provided a copy of the plan, and the template was not used for 7 of the 10 treatment plans. Case Manager assignment was unclear for all 10 outpatients, and case management was sporadic.

[6] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

Recommendation

9. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are consistently completed using the required template and are provided to patients and/or their families and that Case Managers are clearly assigned to polytrauma outpatients and provide consistent case management.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	FPPE for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
X	The facility complied with any additional elements required by local policy.

FPPE. Local policy requires the use of a form that defines the criteria to be used to evaluate the performance of newly hired licensed independent practitioners, such as EHR reviews, direct observation, and discussion with peers. We reviewed the profiles of 10 newly hired licensed independent practitioners and found that for 2 of the practitioners, the form was not completed.

Recommendation

10. We recommended that processes be strengthened to ensure that the required form is completed for all newly hired licensed independent practitioners.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 14 training files and interviewed key employees. Additionally, we reviewed the actual nursing HPPD for an inpatient medical/surgical unit for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
X	The selected unit's actual nursing HPPD met or exceeded the target nursing HPPD.
	The facility complied with any additional elements required by local policy.

Variance Between Actual Nurse Staffing and Target. VHA requires that the facility's target nursing HPPD be used to plan for staffing and to evaluate actual staffing.[7] The unit's average actual nursing HPPD were significantly below the target for the three groups of days reviewed.

Recommendation

11. We recommended that facility nurse managers reassess the target nursing HPPD to accurately plan for staffing and evaluate the actual staffing provided.

[7] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Review Activity With Previous CAP Recommendations

Follow-Up on Respirator Fit Testing

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with respirator fit testing.

Respirator Fit Testing. The Occupational Safety and Health Administration requires that facilities using disposable particulate respirators fit test designated employees annually. During the previous CAP review, we reviewed 25 employee records and found that 14 designated employees did not have the required annual respirator fit testing. In response to the recommendation from that review, the facility required designated employees to get medical clearance and make appointments with the Safety Office to complete their respirator fit testing. However, the respirator program compliance report we received dated April 10, 2012, showed that 768 (68 percent) of 1,125 designated employees were past due for their annual respirator fit testing.

Recommendation

12. We recommended that processes be strengthened to ensure that annual respirator fit testing is completed for all designated employees and that compliance is monitored.

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 22 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[8] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients who for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
	The facility complied with any additional elements required by local policy.

[8] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 18 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 23–30, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care medical center with a community living center, domiciliary, and outpatient clinics	
Complexity Level	1a	
VISN	8	
Community Based Outpatient Clinics	Bradenton, FL Fort Myers, FL Naples, FL Palm Harbor, FL	Port Charlotte, FL Sarasota, FL Sebring, FL St. Petersburg, FL
Veteran Population in Catchment Area	313,385	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	153 medical/surgical 33 MH 99 domiciliary	
• **Community Living Center**	112	
• **Other**	N/A	
Medical School Affiliation(s)	University of South Florida Florida State University Nova Southeastern University Lake Erie College of Osteopathic Medicine	
• **Number of Residents**	41.9	
	Current FY (through January 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$538	$654
• **Medical Care Expenditures**	$201	$651
Total Medical Care Full-Time Employee Equivalents	3,297	3,296
Workload:		
• **Number of Station Level Unique Patients**	73,870	98,951
• **Inpatient Days of Care:**		
o **Acute Care**	17,961	56,022
o **Community Living Center/Nursing Home Care Unit**	10,324	32,077
Hospital Discharges	3,810	11,621
Total Average Daily Census (including all bed types)	315	329
Cumulative Occupancy Rate (in percent)	79	83
Outpatient Visits	433,064	1,262,825

[9] All data provided by facility management.

VHA Satisfaction Surveys

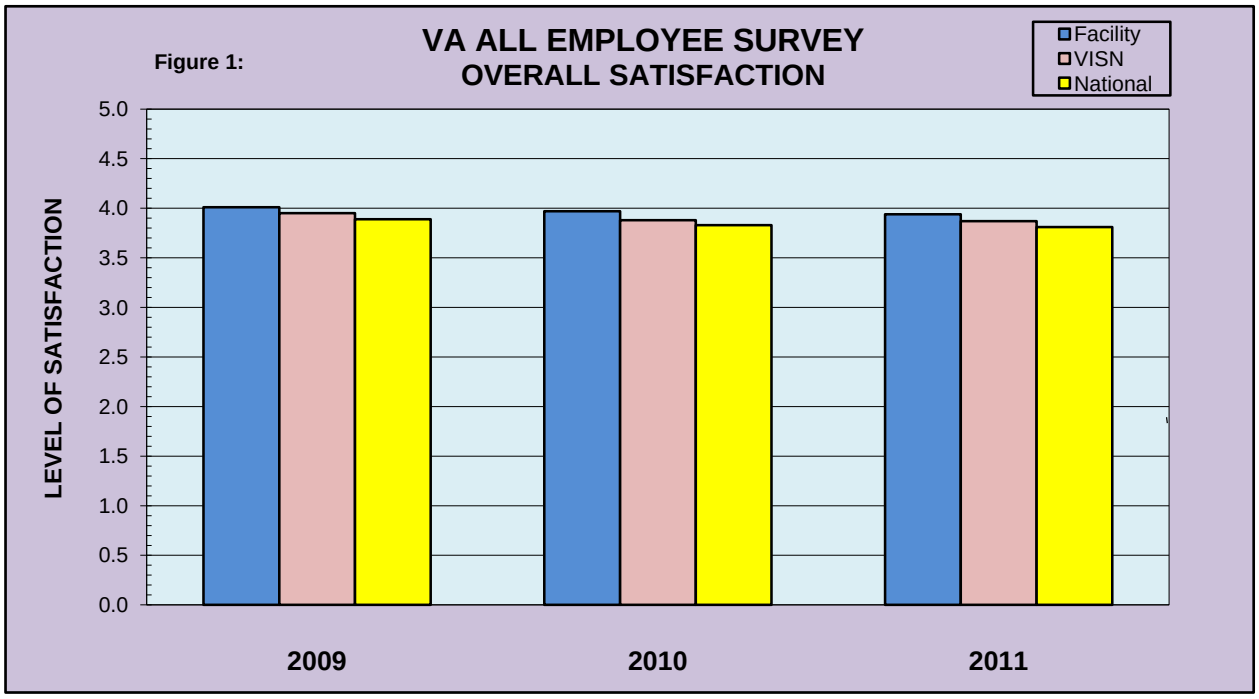
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	70.4	65.6	59.7	57.6	61.1	60.5
VISN	68.1	63.7	56.6	58.2	55.6	58.8
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[10] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[11]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	17.6	11.9	11.8	20.7	24.8	18.8
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[10] A heart attack occurs 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 timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[11] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2012

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

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

To: Associate Director, Bay Pines Regional Office of Healthcare Inspections (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 Bay Pines VA Healthcare System, Bay Pines, Florida.

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

Thank you,

Nevin M. Weaver

Nevin M. Weaver, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2012

From: Director, Bay Pines VA Healthcare System (516/00)

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

To: Director, VISN 8 (10N8)

1. The recommendations made during the Office of Inspector General (OIG) Combined Assessment Program (CAP) Review conducted April 9–13, 2012 have been reviewed and our comments and implementation plan are noted below. I appreciate the OIG's comprehensive review and efforts to ensure high quality care to our Veterans.

2. If you have any questions or require additional information, please contact Joanna Eastman-Gaudreau, Risk Manager, at 727-398-9317.

SUZANNE M. KLINKER

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect sufficient discussion, progress toward resolution, and tracking of items to closure.

Concur

Target date for completion: May 30, 2012

Facility response: The EOC Committee (EOCC) has implemented tracking mechanisms to capture significant discussion, report progress, and track the outcomes of various action items identified in EOCC, as well as ensure continuous follow up to long term issues when necessary. The EOCC recorder was re-trained on the importance of documenting detailed discussion for inclusion into minutes and the PI tracking tool when appropriate. EOCC co-chairs will carefully review each months' meeting minutes to ensure appropriate documentation of discussion and that items are followed through to closure. EOCC co-chairs will carefully review each month's meeting agendas to ensure open items are carried forward at the appropriate time frame and included for discussion as necessary.

Recommendation 2. We recommended that processes be strengthened to ensure that all required participants or their designees attend EOC rounds.

Concur

Target date for completion: May 30, 2012

Facility response: BPVAHCS Leadership re-circulated DUSHOM memo dated 2007 to all required participants in the Weekly EOC Leadership Rounds (EOC-LR) process; the message was specific to reinforcing the requirement for participation as well as to strengthen current process and procedures. BPVAHCS utilizes an automated process to track all EOC deficiencies; the automated tool also tracks attendance by discipline. Monthly summary reports of EOC-LR attendance and process issues will be reported at EOC Committee monthly meetings. Noted deficiencies and/or lack of regular attendance will be directed to the appropriate management official for corrective action.

Recommendation 3. We recommended that processes be strengthened to ensure that the facility's hazardous materials inventory is current.

Concur

Target date for completion: June 1, 2012

Facility response: Station Memorandum 516-12-00-159 Appendix E, Hazard Communication Program, was reviewed to verify inclusion of existing annual chemical inventory requirements. The Station Memorandum was updated and approved for distribution the week of May 21st. This Memorandum contains a due date for Services to have their updated inventories completed annually. An Action Item was initiated May 14, 2012, to all Services to immediately update chemical inventories and submit copies to Safety and Emergency Management Service by May 30, 2012. As of May 29, 2012, 100 percent of the required chemical inventories have been updated and submitted to Safety and Emergency Management Service.

Recommendation 4. We recommended that processes be strengthened to ensure that resident room contraband inspections are consistently conducted and documented and that daily room inspections for unsecured medications are completed.

Concur

Target date for completion: May 30, 2012

Facility response: A new process for documenting and monitoring resident random room searches for contraband and unsecured medications was developed and approved by both Mental Health and Nursing leadership; at least 10 percent of the resident rooms are searched weekly and the specific completed searches are documented on a spreadsheet. The new process for the required room searches also includes a checklist and a rotation of clinical staff from the various domiciliary programs. The staff initials the checklist to confirm the areas that have been searched and provide specific findings. The checklist is returned to the Section Chief or designee responsible for the areas inspected. The Section Chiefs or designee will take any necessary actions to ensure that corrective and timely actions are taken. The Section Chiefs will provide a summary report to the Chief of Mental Health & Behavioral Health Sciences Service through the Performance Improvement Committee on a monthly basis verifying their compliance with conducting and documenting room searches for unsecured medications and contraband. In addition, nursing staff have a protocol/procedure for daily room inspections that check for cleanliness, medication security, and other safety issues. This is documented by the nursing staff and monitored by the Nurse Manager to ensure compliance.

Recommendation 5. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: October 31, 2012

Facility response: In order to strengthen the process, Service templates for history and physical examinations and/or pre-sedation assessments are being updated to include all required elements. A monitoring process to ensure complete documentation of the required elements was reviewed and approved at the Operative and Invasive Procedures Committee (OOIP) on May 22, 2012. Services will monitor documentation monthly and report findings to the OOIP. First reports are due in July. Bay Pines VAHCS Memorandum 11-048 Sedation and Anesthesia Care has been updated to include all required elements of assessment and is undergoing the approval process.

Recommendation 6. We recommended that processes be strengthened to ensure that discharged MH patients receive 7-day post-discharge follow-up and that compliance is monitored.

Concur

Target date for completion: June 6, 2012

Facility response: On May 7, 2012, all MH Health Administration Service (HAS) scheduling staff were advised of the requirement to include the comments "7 day FU post discharge" in all post discharge follow-up appointments. MH HAS scheduling staff are reviewing the appointment of a scheduled patient before any clinic/patient cancellations occur to ensure patients aren't scheduled outside the seventh day. MH HAS scheduling staff are communicating to the MH Section Chief or designee any patients that fell outside the required time frame in order to ensure the patient is seen before the seventh day. The process is monitored by spreadsheet and located on the MH&BSS Group Drive. The spreadsheet includes the patient's name, SSN, date of discharge, date patient is scheduled, date patient must be scheduled, and the last column indicates whether the patient passed or failed the measure. The spreadsheet is updated throughout each day of newly discharged patients by either the Social Worker or clerk assigned to the inpatient units. The Outpatient staff (PSA, SW, Mental Health leads) has access to spreadsheet and updates the spreadsheet as appropriate. The MH Data Analyst monitors the overall process to ensure patients are being scheduled within the 7 day post discharge. The MH Data Analyst prepares a summary report to the MH Performance Improvement Committee on a monthly basis verifying compliance and making recommendations on methods to strengthen the current process. This summary report will be included in the MH Performance Improvement Committee starting June 6, 2012.

Recommendation 7. We recommended that processes be strengthened to ensure that discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

Concur

Target date for completion: June 6, 2012

Facility response: During the Friday May 18, 2012 MH Section Chief's meeting, the Suicide Prevention Case Manager provided education on the measure on ensuring discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals. The Suicide Prevention Team has a process currently being used to monitor old and new patients with high risk for suicide flags. The tracking sheet includes: Veteran name, Last 4, Flag set date, Safety Plan, Admission, Discharge, 1st date, 2nd date, 1st–2nd deadline date, 3rd date, 4th date, 3rd–4th deadline date, results, and notes of issues encountered. The Program Support Assistants are updating the spreadsheet daily by adding new veterans, checking patients that have upcoming appointments in VISTA/CPRS to ensure their appointments are scheduled and scheduled appropriately, updating changes in veterans status i.e. incarcerations, and making additional notes of communications of providers' attempts to reach no-showed patients. In order to help ensure that Veterans with assigned suicide risk flags are keeping their mental health appointments, a new practice is being implemented that the Suicide Prevention team will be notified if a patient with a flag is a "no-show" for a mental health appointment and the clinician or suicide prevention team will address the 'notification/reminder" in CPRS. This process will be monitored by the Suicide Prevention program and a summary report will be provided to the MH Performance Improvement Committee starting June 6, 2012.

Recommendation 8. We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated and documented and that compliance is monitored.

Concur

Target date for completion: June 20, 2012

Facility response: On Tuesday, May 15, 2012, the CPRS Workgroup approved the use of a PROVIDER TRACKER note that is configured to serve as a reminder system for MH providers to track their attempts to contact patients. Once they have completed the contact with the patient they can delete the reminder. The reminder system is in pilot stage and is set to be implemented June 7, 2012. All providers will be trained on this new tool by June 20, 2012. This tool will be monitored by the provider and they will document each attempt in CPRS. Each MH section has conducted a training session on proper documentation of no-show patients and Section Chiefs are able to monitor these attempts by pulling the "No Show Note" title report to audit provider charts during monthly chart reviews. MH Section Chiefs are reporting this data monthly to the MH Performance Improvement Committee.

Recommendation 9. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are consistently completed using the required template and are provided to patients and/or their families and that Case Managers are clearly assigned to polytrauma outpatients and provide consistent case management.

Concur

Target date for completion: July 31, 2012

Facility Response: As of May 22, 2012, the Interdisciplinary (ID) Treatment Team implemented the required ID template, which clearly identifies an assigned case manager, at their weekly meeting. The assigned Case Manager will meet with the veteran or veteran and family to discuss his/her treatment plan and provide a copy of the plan to the veteran. If a face-to-face meeting is not possible the plan will be reviewed over the telephone and mailed to the veteran. Compliance is monitored monthly and is on the service's performance improvement plan. Results are reported quarterly at the administrative officers committee.

Recommendation 10. We recommended that processes be strengthened to ensure that the required form is completed for all newly hired licensed independent practitioners.

Concur

Target date for completion: Completed

Facility response: The FPPE data collection form has been modified to include instructions clarifying how the users are to complete the form for all newly hired licensed independent practitioners. Effective May 2, Credentialing and Privileging staff implemented a compliance checklist to ensure that all essential elements of the form are properly completed prior to the MSEB-Credentialing Session. The FPPE forms for newly hired licensed independent practitioners being reviewed at the May 2 MSEB meeting were reviewed using the compliance checklist and 100 percent were completed fully. In addition, the Chairperson along with the MSEB membership evaluated the scope and relevance of the FPPE plans to the clinical privileges delineated for the providers.

Recommendation 11. We recommended that facility nurse managers reassess the target nursing HPPD to accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: September 30, 2012

Facility response: Bay Pines HCS Nurse Executive Board (NEB) assures that staffing is adequate through several monitoring mechanisms. Hours Per Patient Day (HPPD) is reviewed by nursing managers on a daily basis; and, by NEB on a quarterly trended

basis. Nurse Sensitive Indicators such as Patient Falls and Infection Rates are monitored as a correlating indicator of staffing adequacy. In compliance with VHA Directive 2010-034, Bay Pines Expert Panel will assess staffing methodology and staffing plans per the annual cycle and will adjust target nursing HPPD if so indicated.

Recommendation 12. We recommended that processes be strengthened to ensure that annual respirator fit testing is completed for all designated employees and that compliance is monitored.

Concur

Target date for completion: June 30, 2012

Facility response: The respirator program is being assessed to determine if appropriate staff are in the program and to evaluate the most appropriate respirator type for staff. The number of staff in the respiratory program has been reduced from 1,125 during the pandemic flu preparation in 2009 to 615 in May 2012. Of these employees, 56 are newly identified as working in areas where they may need respirators but have not yet been fit tested or issued respirators. Thirty employees have been issued Powered Air Purifying Respirator (PAPR), which do not require annual fit testing. Of the remaining 519 employees who have been issued respirators, 399 (77 percent) are in compliance with annual fit testing. The facility has set up additional fit testing areas along with staff to perform the testing with expected compliance of 100 percent by June 30, 2012. BPVAHCS Memorandum 00-168, Personal Protective Equipment has been updated and is circulated for concurrence. The respirator fit testing procedure has been revised so that annual Fit testing will be accomplished within a designated month for each Service. Services will be notified by Safety of the month when all identified employees in the service will be required to complete their fit testing.

The appropriateness of respirator type is under assessment. The Safety Office currently has two types of respirators, the North Half Mask and the PAPR. The PAPR does not require fit testing, is more comfortable for staff to wear, and is easier to talk more clearly while wearing. The Safety Office will continue to assess conversion to the PAPRs for staff in most areas.

OIG Contact and Staff Acknowledgments

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