
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-03075-52**

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

**December 7, 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 |
| CLC | community living center |
| COC | coordination of care |
| CRC | colorectal cancer |
| ED | emergency department |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Miami VA Healthcare System |
| FSBG | finger stick blood glucose |
| FY | fiscal year |
| HF | heart failure |
| IC | infection control |
| JC | Joint Commission |
| MH | mental health |
| MSDS | Material Safety Data Sheet |
| OIG | Office of Inspector General |
| POCT | point-of-care testing |
| QM | quality management |
| RRTP | residential rehabilitation treatment program |
| SCI | spinal cord injury |
| 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 September 17, 2012.

**Review Results:** The review covered 10 activities. We made no recommendations in the following three activities:

- Coordination of Care
- Nurse Staffing
- Polytrauma

The facility's reported accomplishment was receiving national recognition and awards for excellence for its Neurology Service.

**Recommendations:** We made recommendations in the following seven activities:

*Environment of Care:* Ensure that Environment of Care-Safety and Infection Control Committee minutes reflect required elements. Conduct a comprehensive inspection of the emergency department environment, and correct infection control and safety deficiencies. Ensure emergency exits are not obstructed. Require that Material Safety Data Sheets are current and that staff are trained to access them electronically. Inspect Spinal Cord Injury Center and outpatient clinic ceiling lifts. Secure medications, chemicals, solutions, and cleaning carts. Conduct monthly and daily Mental Health Residential Rehabilitation Treatment Program inspections, and document follow-up.

*Moderate Sedation:* Include all required elements in pre-sedation assessment documentation. Ensure informed consents are completed appropriately.

*Medication Management:* Ensure all patients in opioid dependence treatment undergo monthly urine drug screenings.

*Mental Health Treatment Continuity:* Ensure that high-risk discharged mental health patients receive follow-up at the required intervals and that attempts to follow up on patients who fail to keep their mental health appointments are initiated timely and documented.

*Colorectal Cancer Screening:* Notify patients of biopsy results within the required timeframe.

*Point-of Care Testing:* Document clinician notification of critical test results on the required template. Update local policies for finger stick blood glucose.

*Quality Management:* Ensure all services complete electronic health record quality reviews.

## 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 10 activities:

- COC
- CRC Screening
- EOC
- 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 September 17, 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 Miami VA Healthcare System, Miami, Florida,* Report No. 11-01099-247, August 11, 2011).

During this review, we presented crime awareness briefings to 1,290 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 490 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 Accomplishment

## Neurology Service

The Neurology Service at the facility has several programs that have been recognized nationally for excellence. The Stroke Program earned the Gold Plus Performance Award from the American Stroke Association and American Heart Association's Get With The Guidelines® program during the 2011–2012 recognition period. This award demonstrates that the facility's Stroke Team is committed to providing care using evidence-based protocols to quickly and efficiently treat acute stroke patients and to implement secondary prevention recommendations and guidelines to improve outcomes for stroke patients.

With help from Clinical Applications staff, the facility's Epilepsy Center of Excellence designed the prototype for the National Epilepsy Template for use in the Computerized Patient Record System. The Neurology Service is also considered a Multiple Sclerosis Center of Excellence. In addition, the facility's Sleep Disorder Center is fully and independently accredited by the American Academy of Sleep Medicine. Only two other VA medical centers in the country have this distinction.

# 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 Post-Traumatic Stress Disorder and Substance Abuse RRTPs complied with selected MH RRTP requirements.

We inspected the surgical intensive care, the immunology/chemotherapy/neurology, the telemetry/surgical, one CLC, the dialysis, the locked inpatient MH, and the Post-Traumatic Stress Disorder and Substance Abuse RRTP units. We also inspected the ED; the chemotherapy, dental, and SCI outpatient clinics; and the SCI Center. 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. |
| X | 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. |
| X | Fire safety requirements were met. |
| X | Environmental safety requirements were met. |
| X | Infection prevention requirements were met. |
| X | Medication safety and security requirements were met. |
| | Sensitive patient information was protected, and patient privacy requirements were met. |
| X | 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 IC practice requirements in the dental clinic were met. |
| | Dental clinic IC 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** |
| X | 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. |

| Noncompliant | 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. |
| X | 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-Safety and IC Committee Activities. The JC requires the facility to monitor and analyze EOC issues and to take action on identified deficiencies until resolved. In addition, local policy requires that EOC-Safety Committee minutes include findings, data analysis reflecting trends, and actions taken related to identified deficiencies. We reviewed EOC-Safety Committee minutes for January through August 2012 and determined that they did not sufficiently reflect data analysis, actions implemented related to identified deficiencies, and tracking of items to closure.

The JC requires the facility to identify risks for acquiring and transmitting infections based on the analysis of surveillance activities and other IC data. We reviewed IC Committee minutes for January through June 2012 and determined that they did not sufficiently reflect data analysis for surveillance activities, actions implemented, and tracking of items to closure.

IC and Safety Issues. The JC requires the appropriate disposal of dirty supplies to minimize or eliminate identified safety and security risks in the physical environment and to prevent the spread of infection. We found multiple IC and safety deficiencies in the ED. Clean and dirty supplies, tubes with blood samples, contaminated needles, used gloves, and patients' personal items were found together on tabletops in 5 of 10 ED cubicles.

Fire Safety. The JC requires that emergency exits be unobstructed. We found that emergency exits were obstructed in the ED, on the Substance Abuse RRTP unit, on the telemetry/surgical unit, and in a hallway next to the chemotherapy clinic.

Hospital Environmental Safety. The JC requires that facilities maintain current MSDS inventory lists and hazardous materials information for chemicals used in clinical areas. Local policy requires that each service maintain one current service-specific hard copy inventory list and hazardous materials information binder in addition to the facility-wide electronic MSDS program. Local policy also requires initial training on MSDS chemicals for new employees and annual training thereafter. Senior managers told us that the MSDS training includes the location of the service MSDS binder and inventory list and how to access chemical inventory and MSDS information electronically. We found that the Nursing Service MSDS binder was not current. We also found that five of seven selected nursing staff were not able to access the electronic MSDS materials.

SCI Environmental Safety. VA requires that an inspection of each ceiling lift in the SCI Center and SCI outpatient clinic be completed after installation and documented on the After Installation Checklist.[1] We requested inspection documentation for 25 SCI Center and SCI outpatient clinic ceiling lifts. There was no documentation of an After Installation Checklist for three of the lifts.

Security of Medications, Chemicals, and Solutions. The JC requires that medications be secured from access by unauthorized persons. We found several unsecured medications on top of a medication cart in an unlocked room being used as a medication room in the immunology/chemotherapy/neurology unit and three normal saline solution syringes on tabletops in the ED. The JC and the Occupational Safety and Health Administration require that chemicals and solutions be appropriately secured to minimize or eliminate safety and security risks in the physical environment. On the dialysis unit, we found several unsecured chemicals and solutions outside the nurses' station and inside treatment rooms. We also found three unlocked and unattended cleaning carts—two on the telemetry/surgical unit and one in a hallway.

MH RRTP Inspections. VHA requires facilities to conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy.[2] We reviewed monthly self-inspection documentation for January through June 2012 and found that monthly self-inspections were not completed for 2 of the past 6 months.

VHA requires that facilities initiate appropriate corrective actions when deficiencies are identified during monthly MH RRTP self-inspections and that inspection reports indicate sufficient follow-up and tracking of items to resolution.[3] We found that the MH RRTP monthly self-inspection reports did not contain sufficient documentation that follow-up actions were tracked to closure.

VHA requires daily room inspections for unsecured medications.[4] We reviewed documentation of daily room inspections for unsecured medications for the months of February and April 2012. We found that unit staff were not consistently documenting that inspections were being conducted.

## Recommendations

**1.** We recommended that processes be strengthened to ensure that EOC-Safety and IC Committee minutes reflect sufficient data analysis, actions implemented, and tracking of items to closure.

**2.** We recommended that a comprehensive EOC inspection of the ED be conducted and that appropriate actions be taken to correct IC and safety deficiencies.

[1] VA National Center for Patient Safety, "Ceiling mounted patient lift installations," Patient Safety Alert 10-07, March 22, 2010.
[2] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[3] VHA Handbook 1162.02.
[4] VHA Handbook 1162.02.

**3.** We recommended that processes be strengthened to ensure that emergency exits are not obstructed.

**4.** We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous materials information binders are current and that staff are trained on accessing the electronic MSDS materials.

**5.** We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the SCI Center and SCI outpatient clinic.

**6.** We recommended that processes be strengthened to ensure that medications, chemicals, solutions, and cleaning carts are properly secured.

**7.** We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections and daily room inspections are conducted and that inspection reports contain adequate documentation of follow-up.

## 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, 10 EHRs, and 19 training/competency 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 |
|---|---|
| | Staff completed competency-based education/training prior to assisting with or providing moderate sedation. |
| X | Pre-sedation documentation was complete. |
| X | 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.[5] We found that six EHRs did not include documentation of all required elements of the history and physical examination, such as a review of previous adverse experience with sedation or substance use.

Informed Consent. VHA requires that the patient be informed about the procedure and given the name of the provider who will perform the procedure.[6] For two patients, the providers who performed the procedures were not the same as the providers listed on the consent forms, and there was no evidence in the EHRs that the change in provider was discussed with and agreed to by the patients.

### Recommendations

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

[5] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers,* May 1, 2006.
[6] VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures,* August 14, 2009.

**9.** We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

## Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[7] 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 area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Opioid dependence treatment was available to all patients 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. |
| X | 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. |

Urine Drug Screening. VHA requires that patients in opioid dependence treatment be monitored through periodic urine drug screening.[8] Facility managers told us that they expected all patients in opioid dependence treatment to undergo urine drug screening monthly during the maintenance phase and that this had been the standard of practice for many years. In addition, facility managers provided us with a policy developed a month prior to our site visit that reflected this standard of practice. We reviewed the EHRs for a 12-month period from August 2011 through July 2012 and found that 9 of the 10 patients had no documentation of monthly urine drug screenings. Documentation reflected that all nine patients had attended at least one clinic appointment during the months the urine drug screenings were not performed.

### Recommendation

**10.** We recommended that processes be strengthened to ensure that all patients in opioid dependence treatment undergo monthly urine drug screenings.

[7] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.
[8] VA/DoD, "Clinical Practice Guideline for Management of Substance Use Disorders (SUD)," August 2009.

## MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 8 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. |
| X | The facility complied with any additional elements required by local policy. |

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[9] Five of the eight patients who were on the high risk for suicide list did not receive MH follow-up at the required intervals.

Contact Attempts. VHA requires MH employees to document efforts to follow up with patients who do not keep scheduled MH appointments.[10] Facility policy requires that providers make same-day attempts to reach patients who do not keep MH appointments. For two of the five patients who failed to keep their scheduled MH appointments, we did not find any documentation of follow-up attempts. For another patient, no attempts were made to contact the patient for 3 days after the missed appointment.

### Recommendations

**11.** 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 be monitored.

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

[9] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[10] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, and VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010.

## 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 area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| 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. |
| X | 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. |

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[11] Of the 19 patients who had a biopsy, 5 EHRs did not contain documented evidence of timely notification.

### Recommendation

**13.** We recommended that processes be strengthened to ensure that all patients are notified of biopsy results within the required timeframe and that clinicians document notification in the EHR.

[11] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).

## 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 VHA, the College of American Pathologists, and The JC.

We reviewed the EHRs of 30 patients who had glucose testing, 12 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 areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| 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. |
| X | 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. |
| X | The facility complied with any additional elements required by VHA or local policy. |

Test Results Management. VHA requires that facilities delineate actions to be taken in response to critical results and that critical results requiring follow-up be communicated to the responsible clinician to ensure that appropriate and prompt actions are taken if indicated.[12] Local policy requires that notification of the ordering provider be documented in the EHR using a "Critical Diagnostic Finding" template. Although 9 of the 10 patients with critical test results had notification documented in the EHR, the required template was not used.

Program Management and Oversight. VHA requires that the facility have standards, procedures, and policies for glucose POCT that include reporting of timely, accurate,

[12] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

and clear test results.[13] Local laboratory and nursing policies addressing FSBG critical values result verification by the laboratory and patient management of extremely low or high blood sugar levels were not consistent with actual practice and required updating.

### Recommendations

**14.** We recommended that processes be strengthened to ensure that clinician notification of critical test results is documented on the required template.

**15.** We recommended that local policies related to FSBG monitoring and patient management be updated to reflect actual practice.

[13] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures,* October 6, 2008.

## 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. |
| | Focused Professional Practice Evaluations for newly hired licensed independent practitioners 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. |
| X | There was an EHR 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. |
| | The facility complied with any additional elements required by local policy. |

EHR Review. VHA requires facilities to conduct EHR quality reviews that include a representative sample of EHRs from each service or program to ensure that appropriate documentation is occurring.[14] We found that 8 of 18 services did not complete quality reviews.

**16.** We recommended that processes be strengthened to ensure that all services complete EHR quality reviews.

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

# 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 29 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. |

## 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 37 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (11AB) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| 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. |
| | The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day. |
| | The facility complied with any additional elements required by local policy. |

## 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, 20 EHRs of patients with positive traumatic brain injury results, and 8 training records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | Providers communicated the results of the traumatic brain injury 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. |
| | Case Managers were appropriately assigned to outpatients and provided frequent, timely communication. |
| | 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-Traumatic Brain Injury System of Care facilities provided an appropriate care environment. |
| | 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 22–29, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

| **Facility Profile[15]** | | |
|---|---|---|
| **Type of Organization** | Tertiary care medical center | |
| **Complexity Level** | 1b | |
| **VISN** | 8 | |
| **Community Based Outpatient Clinics** | Sunrise, FL<br>Deerfield Beach, FL<br>Hollywood, FL<br>Homestead, FL<br>Key Largo ,FL<br>Key West ,FL<br>Miami ,FL<br>Pembroke Pines, FL | |
| **Veteran Population in Catchment Area** | 174,158 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial RRTP** | 234 | |
| • **CLC/Nursing Home Care Unit** | 110 | |
| • **Other** | None | |
| **Medical School Affiliation(s)** | University of Miami Miller School of Medicine | |
| • **Number of Residents** | 164 | |
| | **Current FY (through June 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $411 | $462 |
| • **Medical Care Expenditures** | $344 | $472 |
| **Total Medical Care Full-Time Employee Equivalents** | 2,542 | 2,616 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 52,189 | 57,342 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 30,486 | 42,849 |
| o **CLC/Nursing Home Care Unit** | 22,518 | 31,662 |
| **Hospital Discharges** | 5,048 | 7,033 |
| **Total Average Daily Census (including all bed types)** | 238 | 244 |
| **Cumulative Occupancy Rate (in percent)** | 69 | 66 |
| **Outpatient Visits** | 560,751 | 766,617 |

[15] All data provided by facility management.

# VHA Satisfaction Surveys

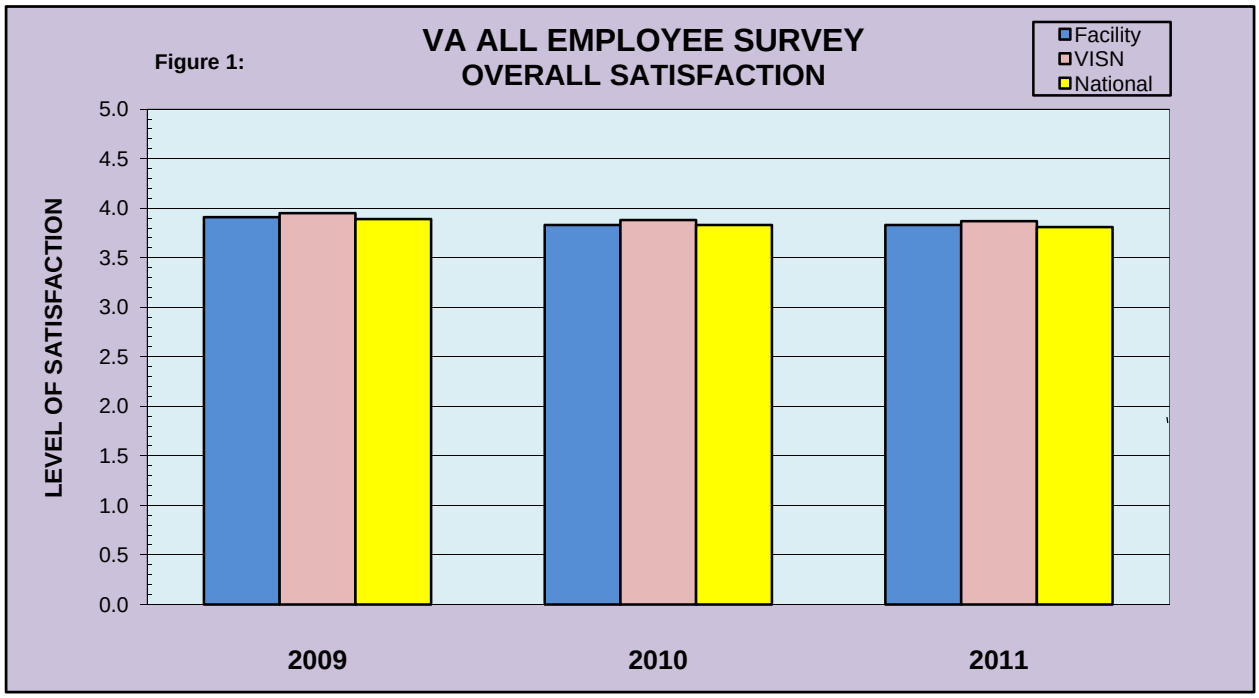
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | FY 2012 | FY 2011 | | FY 2012 | |
| | Inpatient Score Quarters 3–4 | Inpatient Score Quarters 1–2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 |
| Facility | 59.0 | 63.2 | 53.0 | 61.4 | 56.5 | 56.4 |
| VISN | 63.7 | 67.9 | 55.6 | 58.8 | 59.4 | 56.5 |
| VHA | 64.1 | 63.9 | 54.2 | 54.5 | 55.0 | 54.7 |

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.[16] 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, 2008, and June 30, 2011.[17]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | 15.6 | 9.5 | 11.8 | 19.6 | 25.5 | 18.5 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[16] 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.

[17] 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:** November 9, 2012

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

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

**To:** Director, Bay Pines Office of Healthcare Inspections (54SP)

Director, Management Review Service (VHA 10AR MRS)

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.

Thank you,

Nevin M. Weaver

Nevin M. Weaver, FACHE

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** November 9, 2012

**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)

Thank you for the opportunity to review the draft report of recommendations from the OIG CAP conducted at the Miami VA Healthcare System. We have reviewed the report from the site visit and concur with the recommendations; corrective action plans with target dates for completion are attached.

Sincerely,

Paul M. Russo, MHSA, FACHE, RD
Medical Center Director

# 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-Safety and IC Committee minutes reflect sufficient data analysis, actions implemented, and tracking of items to closure.

Concur

Target date for completion: March 31, 2013

Training was offered to all staff responsible for minute taking on October 1, 2012. Staff members responsible for the EOC-Safety and IC Committee minutes will be provided with training by November 30, 2012. A tracking log will be maintained and updated at each committee meeting by the Chair and minute recorder. Items will be maintained on the log until resolved. Tracking log items will be a standing agenda item at every meeting.

**Recommendation 2.** We recommended that a comprehensive EOC inspection of the ED be conducted and that appropriate actions be taken to correct IC and safety deficiencies.

Concur

Target date for completion: December 15, 2012

The EOC rounds schedule was modified to reflect that the ED setting will be monitored on a more frequent basis. The EOC multidisciplinary team conducted an inspection on September 19, 2012 in the ED; where environmental, safety, and other areas were assessed. There is another multidisciplinary EOC rounds inspection scheduled for November 7, 2012 to continue to follow-up on identified deficiencies and assess corrective action. A follow-up report with deficiencies and corrective action will be forwarded after scheduled inspections. EMS has developed an ED Standard Operating Procedure for cleanliness upkeep, including scheduled floor care maintenance upkeep, and has assigned a staff member to cover all three shifts. The ED conducted in-service training for staff to address infection control and safety deficiencies.

**Recommendation 3.** We recommended that processes be strengthened to ensure that emergency exits are not obstructed.

Concur

Target date for completion: November 30, 2012

Immediate action was taken during the review and on the spot education was provided to staff. Carts blocking any egress were removed. EMS will provide training on proper utilization and storage of all carts to maintain unobstructed emergency exits by November 30, 2012. EMS will have dedicated staff (1 FTEE) to remove soiled linens and trash waste to help maintain emergency exits unobstructed. Environmental Health and Safety will develop an educational memorandum to inform all staff about the importance of maintaining corridors and emergency exits unobstructed. This memorandum will be communicated to all staff.

**Recommendation 4.** We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous materials information binders are current and that staff are trained on accessing the electronic MSDS materials.

Concur

Target date for completion: November 30, 2012

Outdated MSDS binders have been removed from all nursing units; MSDS binders have been updated and will now be located in Nursing Supervisor Office. A process for updating on an ongoing basis is being defined. Nursing New Employee Orientation has been revised to include the process on how to access the MSDS website. A flowchart of the process on how to access the MSDS website was sent to all staff as a visual aide. IRMS placed the MSDS Website on the Intranet under Favorites for quick and easy access. The nurse educators will initiate random checks beginning November 13, will be responsible for conducting random checks for their areas, and will create a sign in sheet to document random checks conducted by Nursing Education staff.

**Recommendation 5.** We recommended that processes be strengthened to ensure that safety inspections are conducted on all ceiling lifts in the SCI Center and SCI outpatient clinic.

Concur

Target date for completion: December 31, 2012

Plans have been developed to re-inspect the three ceiling lifts in SCI Center for rooms (112, 113C and 128). Each ceiling lift will have an individual report with their safety result inspection by room number. The Chief of Biomedical Services will assure re-inspection is reported to the Associate Director.

**Recommendation 6.** We recommended that processes be strengthened to ensure that medications, chemicals, solutions, and cleaning carts are properly secured.

Concur

Target date for completion: November 13, 2012

Nurse Managers and the Acting Chief Acute Care Services met with 12CD and ED staff to reinforce medication security. Staff was instructed that medications are to be secured at all times and not left on top of medication carts or in unlocked rooms. Immediately upon OIG's Exit Briefing, two locked carts to securely store chemicals were ordered. These carts were received October 18, 2012. Staff was in-serviced on carts intended purpose of storing jugs of dialysis chemicals only (acid and bicarbonate) and that they are to remain locked at all times to assure security of dialysis chemicals/solutions. Staff was in-serviced October 15, 2012 and reinforced November 6, 2012. EMS will re-enforce the importance of chemical and solution security to eliminate safety risks in the environment. EMS ordered new cleaning carts to replace broken carts and these were received on September 17 and October 24, 2012. Training will be provided to EMS staff on November 13, 2012 to address security issues with unattended and unlocked cleaning carts. Supervisors will monitor chemical and solution security and assure cart integrity is maintained.

The security of medications, chemicals, solutions will be validated through EOC Readiness Rounds and the Tracer Program.

**Recommendation 7.** We recommended that processes be strengthened to ensure that monthly MH RRTP self-inspections and daily room inspections are conducted and that inspection reports contain adequate documentation of follow-up.

Concur

Target date for completion: Completed October 2, 2012

Miami VA MHRRTP Director will monitor MHRRTP program managers monthly to assure that self-inspections have been completed each month. Spreadsheets validating monthly inspections will be maintained by the Chief, Psychology Service.

**Recommendation 8.** We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: Completed September 27, 2012

Pre-sedation templates have been modified to include a force field response for review of previous adverse experience with sedation and substance abuse.

**Recommendation 9.** We recommended that processes be strengthened to ensure that all informed consents are completed appropriately and that any changes to the consents are discussed with and approved by the patients prior to administration of sedation.

Concur

Target date for completion: December 31, 2012

The Chief of Staff notified attending providers responsible for the supervision of operative and other invasive procedures on November 6, 2012 that informed consents are to include the name of the provider performing the procedure. The attending will review consent the day of operative/invasive procedure to assure provider performing procedure is correctly noted and any changes discussed and approved by patient prior to sedation and the start of the procedure. This will be documented in the EHR. QM will review sample size procedures to assure corrective actions have been successfully implemented and the provider noted as on the consent is the provider performing the procedure per the invasive procedure note. This issue was discussed at Operative and Invasive Procedure Committee on September 24 and October 22, 2012.

**Recommendation 10.** We recommended that processes be strengthened to ensure that all patients in opioid dependence treatment undergo monthly urine drug screenings.

Concur

Target date for completion: December 31, 2012

A new Opioid Dependence Treatment Policy has been written that eliminates the need for monthly urine drug screening: "Random UDS will be performed periodically during buprenorphine treatment. Urine drug screen frequency will depend on the veteran's progress in treatment but will not be less frequent than every six months." A six month review will be performed to assure UDS are being performed subsequent adherence to this policy will be monitored on an annual basis and reported to the Chief of Staff.

**Recommendation 11.** 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 be monitored.

Concur

Target date for completion: January 31, 2013

The ACOS/Mental Health met with all current and former Suicide Prevention Coordinators to review core competencies and expectations for clinical management of high risk patients. SPC are monitoring high risk patients to assure that these patients are directly contacted at least weekly during the first 30 days after discharge and that the weekly contacts are documented in the medical record. A compliance report will be provided by each SPC to the ACOS for Mental Health at the end of every week and a monthly aggregate report will be reported to the Chief of Staff.

In order to meet the increasing demand for follow-up of discharged MH patients who are on the high risk for suicide list, 1 FTEE (MH/SW/RN) has been approved for recruitment with the announcement being posted no later than November 9, 2012. The goal will be to expedite the recruitment efforts and have this position on-board no later than January 1, 2013. This position will address this function and the function described in 11. Compliance will be monitored on a regular basis.

**Recommendation 12.** We recommended that processes be strengthened to ensure that attempts to follow up with patients who fail to keep their MH appointments are initiated timely and documented and that compliance be monitored.

Concur

Target date for completion: January 31, 2013

This OIG recommendation was discussed at Mental Health Council on September 24, 2012. Mental Health Staff Education was re-enforced and staff was instructed during an all mental health staff meeting on November 9, 2012 that a same day attempt to contact the patient after a no-show for appointment must be made and documented in the medical record. MH staff will monitor all no-show appointments for documentation of same day attempts to contact patient. A compliance report will be provided to the ACOS/MH for each provider on a monthly basis and a monthly aggregate report will be reported to the Chief of Staff.

In order to meet the increasing demand for follow-up of discharged MH patients who are on the high risk for suicide list, 1 FTEE (MH/SW/RN) has been approved for recruitment with the announcement being posted no later than November 9, 2012. The goal will be to expedite the recruitment efforts and have this position on-board no later than January 1, 2013. This position will address this function and the function described in 12. Compliance will be monitored on a regular basis.

**Recommendation 13.** We recommended that processes be strengthened to ensure that all patients are notified of biopsy results within the required timeframe and that clinicians document notification in the EHR.

Concur

Target date for completion: November 30, 2012

GI Staff has worked collaboratively with Clinical Applications Coordinators (CACs) to develop the following actions to help ensure patients are informed of biopsy results in required timeframe:

- Discharge instructions to patients include information about pending results and request patients to call within 14 days if we have not provided results.
- Documentation tools using health factors to track all pathology are being developed.
- The first follow-up report will be printed daily by GI staff to inform providers/attending that pathology reports are pending, this report is generated from the Invasive Procedure Note Template when a procedure with pathology is identified.
- Results reporting, the second report notes communication of the results to the patient, this report is generated from the Test Reconciliation GI Procedure Template.

- GI staff will reconcile the two reports to assure results are communicated to the patient within 14 days.

**Recommendation 14.** We recommended that processes be strengthened to ensure that clinician notification of critical test results is documented on the required template.

Concur

Target date for completion: December 31, 2012

The policy on critical test results: HSPM 11-03-10 will be revised to describe the appropriate documentation of POC finger stick blood glucose critical results by Nursing Service.

In July 2012 Nursing and Laboratory Service worked together to provide education to nurse managers, inpatient staff and ED staff on the process for critical results.

Corrective actions will be monitored for compliance.

**Recommendation 15.** We recommended that local policies related to FSBG monitoring and patient management be updated to reflect actual practice.

Concur

Target date for completion: December 31, 2012

The critical test reporting policy: HSPM 11-03-10 and the hypoglycemia protocol policy: HSPM 118-19-11 will be revised to reflect the appropriate practice by nursing staff.

**Recommendation 16.** We recommended that processes be strengthened to ensure that all services complete EHR quality reviews.

Concur

Target date for completion: January 30, 2013

A new automated process is being designed with core elements. Each service will review for inclusion of additional service specific elements. Software will be uploaded and icon placed on desktop and education will be provided to the end users.

Medical records committee will monitor compliance and report to MEC at least quarterly.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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