Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01971-245

Combined Assessment Program Review of the James A. Haley Veterans' Hospital Tampa, Florida

July 18, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CPC	Comprehensive Pain Center
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	James A. Haley Veterans' Hospital
FY	fiscal year
HPC	hospice and palliative care
IC	infection control
MH	mental health
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
OR	operating room
PCCT	Palliative Care Consult Team
QM	quality management
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of June 3, 2013.

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

- Coordination of Care – Hospice and Palliative Care
- Pressure Ulcer Prevention and Management
- Nurse Staffing

The facility's reported accomplishments were implementation of an innovative medication safety curriculum and the Comprehensive Pain Center, which offers interdisciplinary pain rehabilitation programs.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure that all services are included in the review of electronic health record quality and that the results of non-VA purchased diagnostic tests are consistently scanned into electronic health records.

Environment of Care: Ensure that Environment of Care Committee minutes reflect identified mental health unit deficiencies, corrective actions taken, and tracking of corrective actions to closure. Secure sterile storage rooms and chemicals stored on the hemodialysis unit at all times. Ensure that the Sterile Processing Service eyewash station is checked weekly, that the decontamination area is clean, and that initial training and competency validation is documented for staff who reprocess reusable medical equipment. Require that operating room staff who perform immediate use sterilization have initial training and competency validation documented and that staff competency validation results and results of compliance with reusable medical equipment standard operating procedures are reported to the Clinical Executive Board.

Medication Management – Controlled Substances Inspections: Ensure that monthly controlled substances findings summaries and quarterly trend reports are provided to the facility Director consistently and timely and that all non-pharmacy areas with controlled substances are inspected monthly.

Construction Safety: Ensure that infection control and tuberculosis risk assessments are conducted prior to construction project initiation and that infection surveillance activities for construction projects are conducted and documented in Infection Control Committee minutes.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- 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 compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing
- Construction Safety

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2012 and FY 2013 through June 3, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the James A. Haley Veterans' Hospital, Tampa, Florida,* Report No. 08-03090-160, July 1, 2009).

During this review, we presented crime awareness briefings for 136 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 1,074 responded. We shared summarized 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

Institute for Safe Medication Practices Award

In 2012, the facility received an award from the Institute for Safe Medication Practices for demonstrating a standard of excellence for prevention of medical errors. The facility developed and implemented a curriculum that emphasizes medication safety and error prevention. The curriculum was created as part of a larger educational innovation movement supported by VHA's Office of Academic Affiliations and is presented to medical students, residents, staff physicians, nurses, pharmacists, and others. Learners attend sessions on patient safety, pharmacy processes, human factors engineering, and identification of potential hazards in a patient's EOC. The curriculum includes hands-on experience that follows a medication from order entry through administration and identifies vulnerabilities and possible solutions. The curriculum also includes participation in an evaluation of a medication device and simulations of hazards in a patient's health care environment. The curriculum has been presented at numerous national conferences and shared widely within VHA.

CPC

The CPC offers a wide range of treatment options through its interdisciplinary pain rehabilitation programs, outpatient medical clinics, and interventional medical services. Treatment focuses on improving physical function and quality of life for veterans experiencing chronic pain. Accredited by the Commission on Accreditation of Rehabilitation Facilities, the CPC has the only inpatient pain treatment program in VHA and includes physical therapy, occupational therapy, recreational therapy, aquatic therapy, psychology, and medical management. The CPC was among the first to identify common co-morbidities of pain and emotional issues among returning Iraq and Afghanistan war veterans and now has a program specifically for this population. As the largest pain management center in the VA system, the CPC has received numerous accolades, including the VA's Olin E. Teague Award and the American Pain Society's Clinical Centers of Excellence in Pain Management Award. The CPC serves as a model and training site for VA interdisciplinary pain programs.

Results and Recommendations

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.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
	Corrective actions from the protected peer review process were reported to the Peer Review Committee.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.	
	Local policy for the use of observation beds complied with selected requirements.	
	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Six months of EHR Committee meeting minutes were reviewed: • Not all services were included in review of EHR quality.
	The EHR copy and paste function was monitored.	

NC	Areas Reviewed (continued)	Findings
X	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	EHRs of 28 patients who had non-VA purchased diagnostic tests reviewed: • Test results of 5 patients were not scanned into the EHRs.
	Use and review of blood/transfusions complied with selected requirements.	
	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	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 VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that all services are included in the review of EHR quality.

2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected the surgical intensive care, the oncology, the telemetry, the surgical, one CLC, one spinal cord injury, the hemodialysis, two locked inpatient MH, and the post-anesthesia care units. We also inspected the emergency department, the chemotherapy clinic, the interventional radiology area, the OR, and the SPS area. Additionally, we reviewed 30 employee training and competency files (10 hemodialysis, 10 OR, and 10 SPS). The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed for General EOC	Findings
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not reflect sufficient discussion of deficiencies identified on the MH units, corrective actions taken, or tracking of actions to closure.
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
X	Environmental safety requirements were met.	• In two areas, sterile storage rooms were unlocked.
	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 VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Hemodialysis	
	The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients.	

NC	Areas Reviewed for Hemodialysis (continued)	Findings
	Monthly biological water and dialysate testing were conducted and included required components, and identified problems were corrected.	
	Employees received training on bloodborne pathogens.	
	Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented.	
X	Selected EOC/infection prevention/safety requirements were met.	• Two carts had unsecured chemicals.
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for SPS/RME	
	The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME.	
X	The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee.	Two quarters of Clinical Executive Board minutes reviewed: • Minutes did not include RME competency validation results and results of compliance with established SOPs.
	The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it.	
X	Employees received required RME training and competency assessment.	SPS staff competency validation documentation reviewed for two different RME items per employee: • Five SPS employees did not have current competency validation for selected RME. • Initial training was not documented for three SPS employees on duty for less than or equal to 2 years for selected RME.
X	OR employees who performed immediate use (flash) sterilization received training and competency assessment.	• Four OR staff did not have initial training and/or competency validation documented for flash sterilization.
	RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required.	
X	Selected infection prevention/environmental safety requirements were met.	• The eyewash station in SPS was not inspected weekly. • The SPS decontamination area was dirty.
	Selected requirements for SPS decontamination and sterile storage areas were met.	

NC	Areas Reviewed for SPS/RME (continued)	Findings
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendations

3. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect deficiencies identified on the MH units, corrective actions taken, and tracking of corrective actions to closure.

4. We recommended that processes be strengthened to ensure that sterile storage rooms are secured at all times and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that chemicals stored on the hemodialysis unit are secured at all times and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that staff competency validation results and results of compliance with RME SOPs are reported to the Clinical Executive Board.

7. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities have initial training and annual competency validation documented.

8. We recommended that processes be strengthened to ensure that OR employees who perform immediate use sterilization have initial training and annual competency validation documented.

9. We recommended that processes be strengthened to ensure that the SPS eyewash station is checked weekly and that compliance be monitored.

10. We recommended that processes be strengthened to ensure that the SPS decontamination area is clean.

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	CS inspection monthly summaries for the past 6 months and quarterly trend reports for the past 4 quarters reviewed: • Summaries and reports were not consistently or timely provided to the facility Director.
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	
X	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	Inspection documentation for 10 CS areas for the past 6 months reviewed: • One monthly inspection was missed in nine different CS areas.
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that processes be strengthened to ensure that monthly CS findings summaries and quarterly trend reports are provided to the facility Director consistently and timely.

12. We recommended that processes be strengthened to ensure that all non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 18 EHRs of patients who had PCCT consults (including 8 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	HPC staff and selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	
	Consult responses were attached to HPC consult requests.	
	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
	HPC inpatients were assessed for pain with the frequency required by local policy.	
	HPC inpatients' pain was managed according to the interventions included in the care plan.	
	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 28 EHRs of patients with pressure ulcers (10 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 8 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected three patient rooms. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NC	Areas Reviewed (continued)	Findings
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or 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 three inpatient units (acute medical/surgical, MH, and long-term care).[6]

We reviewed relevant documents and 25 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for acute medical/surgical unit 4 North, MH unit ARC-1, and the CLC unit for 52 randomly selected days (holidays, weekdays, and weekend days) between October 1, 2012, and March 31, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.	
	The unit-based expert panels followed the required processes and included all required members.	
	The facility expert panel followed the required processes and included all required members.	
	Members of the expert panels completed the required training.	
	The 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 VHA or local policy.	

Construction Safety

The purpose of this review was to determine whether the facility maintained IC and safety precautions during construction and renovation activities in accordance with applicable standards.[7]

We inspected the CLC construction project. Additionally, we reviewed relevant documents and 15 training records (4 contractor records and 11 employee records), and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

NC	Areas Reviewed	Findings
	There was a multidisciplinary committee to oversee IC and safety precautions during construction and renovation activities and a policy outlining the responsibilities of the committee, and the committee included all required members.	
X	IC, preconstruction, interim life safety, and contractor tuberculosis risk assessments were conducted prior to project initiation.	Risk assessments reviewed: • IC and tuberculosis risk assessments were not conducted prior to project initiation.
NA	There was documentation of results of contractor tuberculosis skin testing and of follow-up on any positive results.	
	There was a policy addressing Interim Life Safety Measures, and required Interim Life Safety Measures were documented.	
	Site inspections were conducted by the required multidisciplinary team members at the specified frequency and included all required elements.	
X	IC Committee minutes documented infection surveillance activities associated with the project and any interventions.	Eight months of IC Committee minutes reviewed: • There was no documentation of infection surveillance activities related to the project.
	Construction Safety Committee minutes documented any unsafe conditions found during inspections and any follow-up actions and tracked actions to completion.	
	Contractors and designated employees received required training.	
	Dust control requirements were met.	
	Fire and life safety requirements were met.	
	Hazardous chemicals requirements were met.	
	Storage and security requirements were met.	
	The facility complied with any additional elements required by VHA or local policy or other regulatory standards.	

Recommendations

13. We recommended that processes be strengthened to ensure that IC and tuberculosis risk assessments are conducted prior to construction project initiation.

14. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC Committee minutes.

Facility Profile (Tampa/673) FY 2013 through April 2013[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$712.3
Number (through May 2013) of:	
• **Unique Patients**	77,296
• **Outpatient Visits**	760,446
• **Unique Employees**[b]	3,528
Type and Number of Operating Beds:	
• **Hospital**	407
• **CLC**	64
• **MH**	33
Average Daily Census:	
• **Hospital**	275
• **CLC**	54
• **MH**	28
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Lakeland/673GB Brooksville/673GC Zephyrhills/673GF
VISN Number	8

[a] All data is for FY 2013 through April 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient 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 FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	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	59.9	65.5	65.4	52.3	57.6	63.1
VISN	67.9	67.3	59.4	56.5	55.4	56.5
VHA	63.9	65.0	55.0	54.7	54.3	55.0

Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] 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.[d]

Table 2

	Mortality			Readmission		
	Heart Attack	Heart Failure	Pneumonia	Heart Attack	Heart Failure	Pneumonia
Facility	13.8	11.2	10.9	25.0	28.9	22.5
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[c] 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. Heart failure 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.

[d] 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: July 8, 2013

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

Subject: **CAP Review of the James A. Haley Veterans' Hospital, Tampa, FL**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

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

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

Thomas Wisnieski, MPA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2013

From: Director, James A. Haley Veterans' Hospital (673/00)

Subject: CAP Review of the James A. Haley Veterans' Hospital, Tampa, FL

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

1. I have reviewed and concur with the findings and recommendations in the report of the OIG CAP Review.
2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

Kathleen R. Fogarty

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 all services are included in the review of EHR quality.

Concur

Target date for completion: October 4, 2013

Facility response: The MRRC has been tracking clinical pertinence reviews monthly and reporting results to the CEB quarterly. One surgical specialty, neurosurgery, had been consistently not performing these reviews. The Chief of Surgery assigned responsibility for these reviews to one neurosurgeon who will begin performing these reviews in July 2013. The Surgical Service Performance Improvement Registered Nurse tracks completion of these reviews and forwards them to the MRRC monthly. The Chief of Surgery will report monthly to the CEB, beginning on July 11, 2013, the status of the neurosurgical clinical pertinence reviews until 90 percent compliance is met.

Recommendation 2. We recommended that processes be strengthened to ensure that the results of non-VA purchased diagnostic tests are consistently scanned into EHRs.

Concur

Target date for completion: October 9, 2013

Facility response: Post OIG, a review of the five (5) records that were missing information were reviewed by the Fee Basis staff. The scanned documents were found in CPRS/vista imaging on 4 of the 5 records. One record was found to be missing the scanned information. The HIMS staff will provide training on proper scanning procedures to the Fee Basis staff for ease in locating these documents. Monitoring of records will show greater than 95 percent of NVCC pts will have appropriate medical records scanned into CPRS. This information will be presented monthly to the PIC until 95 percent compliance is attained.

Recommendation 3. We recommended that processes be strengthened to ensure that EOC Committee minutes reflect deficiencies identified on the MH units, corrective actions taken, and tracking of corrective actions to closure.

Concur

Target date for completion: October 10, 2013

Facility response: The EOC MH checklist was being completed by the MH Multidisciplinary Safety Inspection with items tracked to completion, reviewed by the ACOS/MH&BS, and forwarded to the VISN on a quarterly basis; however, it was not brought to the EOC Committee for discussion and tracking. The EOC MH Checklist is now a standing agenda item for the EOC Committee on a quarterly basis. On June 13, 2013, the EOC MH checklist was presented to the EOC Committee. All open items will be tracked to completion through the EOC committee on a monthly basis for four months and then on a quarterly basis.

Recommendation 4. We recommended that processes be strengthened to ensure that sterile storage rooms are secured at all times and that compliance be monitored.

Concur

Target date for completion: October 10, 2013

Facility response: On June 14, 2013, the 4 South storage room lock was changed to key only access and change of shift handoff by 4S Charge Nurses was implemented to ensure the storage room is secured (locked) and in appropriate order. Monitoring of the storage room will be performed and reported to the EOC monthly for four months until 95 percent compliance is met.

On June 4, 2013, the staff in the Interventional Radiology suite were educated to keep the storage room closed and locked. The Nurse Manager will be responsible for ensuring that staff keep the storage door closed and locked. Monitoring of storage room will be performed and reported to the EOC monthly for four months until 95 percent compliance is met.

Recommendation 5. We recommended that processes be strengthened to ensure that chemicals stored on the hemodialysis unit are secured at all times and that compliance be monitored.

Concur

Target date for completion: October 10, 2013

Facility response: All dialysis chemicals are now stored in a locked storage room as of June 7, 2013. The Hemodialysis Nurse Manager will perform random checks for four months to ensure all dialysis chemicals are locked in the clean supply room. This information will be reported monthly to the EOC committee monthly for four months.

Recommendation 6. We recommended that processes be strengthened to ensure that staff competency validation results and results of compliance with RME SOPs are reported to the Clinical Executive Board.

Concur

Target date for completion: September 5, 2013

Facility response: The requirement for including staff competency validation results and results of compliance has been added to the quarterly RME report to the CEB. The Associate Director for Patient Care/Nursing Services will continue to provide RME quarterly reports to the Clinical Executive Board that include the status of completion of staff competency validation results and compliance results.

Recommendation 7. We recommended that processes be strengthened to ensure that SPS employees responsible for reprocessing activities have initial training and annual competency validation documented.

Concur

Target date for completion: August 12, 2013

Facility response: The RME educator position has been vacant for over a year but was filled (on board) as of July 1, 2013. This person is responsible for ensuring that all competencies are completed and include relevant equipment. The week of June 13, 2013, a review of all RME competencies was conducted to determine status of competencies. The supervisor in RME has been working to update competency folders to ensure they include the required documentation (still in progress). The Chief Nurse for SPS will report on compliance for all RME competencies to the RME Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that OR employees who perform immediate use sterilization receive have initial training and annual competency validation documented.

Concur

Target date for completion: July 8, 2013

Facility response: Same as Recommendation #7 for RME educator. As of July 3, 3013, 33 of 38 (87 percent) of OR staff have had their competency folders reviewed and updated to include documentation of initial training for IUSS and annual competency validation. The Chief Nurse for SPS will report to the RME Committee on the compliance with IUSS for OR staff competencies.

Recommendation 9. We recommended that processes be strengthened to ensure that the SPS eyewash station is checked weekly and that compliance be monitored.

Concur

Target date for completion: October 10, 2013

Facility response: The location of this eye wash station is in a remote location and was overlooked by staff. On June 10, 2013, SPS staff were assigned responsibility for checking eyewash stations weekly. Compliance for the past four weeks is 100 percent. Compliance with weekly checks will be reported to the EOC Committee monthly until a compliance of 95 percent is met for four consecutive months.

Recommendation 10. We recommended that processes be strengthened to ensure that the SPS decontamination area is clean.

Concur

Target date for completion: October 10, 2013

Facility response: A cleaning schedule was developed for the SPS decontamination area on June 10, 2013. The Assistant Chief SPS and/or Chief Nurse will conduct spot checks of the decontamination area for cleanliness and report findings to the RME committee.

Recommendation 11. We recommended that processes be strengthened to ensure that monthly CS findings summaries and quarterly trend reports are provided to the facility Director consistently and timely.

Concur

Target date for completion: November 6, 2013

Facility response: Monthly reports will be forwarded to the Director by the 21st day of the following month. Quarterly trend reports will be forwarded to the Director within 30 days of the close of the quarter. The timeliness reports will be tracked by the Compliance Committee beginning August 7, 2013.

Recommendation 12. We recommended that processes be strengthened to ensure that all non-pharmacy areas with CS are inspected monthly and that compliance be monitored.

Concur

Target date for completion: November 6, 2013

Facility response: A schedule of inpsections will be made for non-pharmacy areas to ensure they are inspected as per VHA requirements. Inspection checklist will be amended to include all required elements. The CSC will report to the Compliance Committee on the status of the program beginning August 7, 2013 (monthly for four months and then quarterly).

Recommendation 13. We recommended that processes be strengthened to ensure that IC and tuberculosis risk assessments are conducted prior to construction project initiation.

Concur

Target date for completion: October 10, 2013

Facility response: The multi-disciplinary team consisting of Infection Control, Contracting Office Representative (COR) or Construction Crew Supervisor, and the Safety Office will conduct and document the ICRA for all construction projects (in house and by contract) during the design or planning stage of work (prior to bidding, purchasing, or starting work) using the Construction Safety Committee approved Pre-Construction Risk Assessment Form. All new construction projects will be presented to the Construction Committee to document in the minutes that the IC and TB risk assessments have been completed prior to construction project initiation.

Recommendation 14. We recommended that processes be strengthened to ensure that infection surveillance activities related to construction projects are conducted and documented in IC Committee minutes.

Concur

Target date for completion: September 10, 2013

Facility response: Construction Projects Infection Control Report will be added to the monthly reporting schedule for the Infection Control Committee. Breaches in compliance with infection control measures and any related infection surveillance activities resulting from construction/renovation projects inspections will be reported monthly to the Infection Control Committee, tracked to completion, and documented in the minutes.

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Endnotes

[1] References used for this topic included:
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