Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01292-258

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

August 28, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	Bay Pines VA Healthcare System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACU	post-anesthesia care unit
PRC	Peer Review Committee
QM	quality management
SDS	same day surgery
tPA	tissue plasminogen activator
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 May 12, 2014.

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

- Medication Management
- Magnetic Resonance Imaging Safety

The facility's reported accomplishments were receiving the VA National Center for Patient Safety Gold Cornerstone Award and being named as a Top Performer on Key Quality Measures® by The Joint Commission.

Recommendations: We made recommendations in the following five activities:

Quality Management: Include most services in the review of electronic health record quality. Ensure the Blood Usage Review Committee member from Surgery Service consistently attends meetings.

Environment of Care: Store oxygen tanks on the 3C surgical, 5B medical, and 4A telemetry units in a manner that distinguishes between empty and full tanks. Lock soiled utility rooms on the 5A medical, east and central community living center, and medical and surgical intensive care units. Secure community living center doors after hours. Include defibrillators in crash cart inspections on the dialysis and locked mental health units, and document the inspections. Ensure that all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually and that all designated eye clinic employees receive eye laser safety training every 2 years.

Coordination of Care: Identify post-discharge needs, and include them in discharge planning. Provide individualized, patient-specific discharge instructions.

Acute Ischemic Stroke Care: Post stroke guidelines on the medical intensive care; 5B medical; and east, central, and west community living center units. Report to the Veterans Health Administration the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Community Living Center Resident Independence and Dignity: Consistently complete and document restorative nursing services according to clinician orders and/or residents' care plans. Provide all care planned/ordered assistive eating devices to residents for use during meals.

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 20–27, for the full text of the Directors' comments.) We consider recommendations 7, 8, and 11 closed. We will follow up on the planned actions for the open recommendations 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met 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
- Coordination of Care
- Acute Ischemic Stroke Care
- CLC Resident Independence and Dignity
- MRI 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 2013 and FY 2014 through May 12, 2014, 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 Bay Pines VA Healthcare System, Bay Pines, Florida,* Report No. 12-00884-197, June 12, 2012).

During this review, we presented crime awareness briefings for 204 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 684 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

Cornerstone Recognition Award

In November 2013, the VA National Center for Patient Safety awarded the facility the Gold Cornerstone Award. The award recognized the facility's work and efficiency in completing root cause analysis processes related to health care quality and patient safety.

Top Performer on Key Quality Measures®

The Joint Commission named the facility a Top Performer on Key Quality Measures® for exemplary performance in using evidence-based clinical processes to improve care. The facility was specifically recognized for its achievement on the measure sets for heart attack, heart failure, pneumonia, and surgical care and was the only VA facility out of 104 Florida public and private hospitals to earn the distinction.

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 met selected requirements within its QM program.[a]

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 NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • Surgical deaths with identified problems or opportunities for improvement were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Twelve months of EHR Committee meeting minutes reviewed: • The review of EHR quality did not include EHRs from Geriatrics and Extended Care or Primary Care Services.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four sets of Blood Usage Review Committee meeting minutes reviewed: • The clinical representative from Surgery Service attended only two of four quarterly meetings.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the review of electronic health record quality includes most services.

2. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Surgery Service consistently attends meetings.

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 the facility met selected requirements in SDS, the PACU, and the eye clinic.[b]

We inspected two medical units, the surgical unit, the telemetry unit, two CLC units, the medical intensive care unit, the surgical intensive care unit, the inpatient MH unit, the dialysis unit, the chemotherapy unit, the SDS unit, the PACU, the eye clinic, and the emergency department. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 25 employee training records (9 SDS, 11 PACU, and 5 eye clinic). The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective 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.	• Oxygen tanks on the 3C surgical, 5B medical, and 4A telemetry units were not stored in a manner that distinguished between empty and full tanks. • Soiled utility rooms on the 5A medical unit, the east and central CLC units, and the medical and surgical intensive care units were not locked.
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	

NM	Areas Reviewed for General EOC (continued)	Findings
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy on the EOC management plan reviewed: • While policy required that patient care areas be secured after hours, the doors from the CLC units to the two smoking porches and the doors from the smoking porches to the outside grounds were not secured, allowing unauthorized access to the units 24 hours per day. Local policy on checking emergency carts and defibrillators/pacemakers reviewed: • While policy required daily inspections of crash carts and defibrillators and documentation of inspections, on the dialysis and locked MH units, crash cart inspections did not include the defibrillators.
	Areas Reviewed for SDS and the PACU	
X	Designated SDS and PACU employees received bloodborne pathogens training during the past 12 months.	• Five of the 20 SDS and PACU employees did not receive bloodborne pathogens training during the past 12 months.
	Designated SDS employees received medical laser safety training with the frequency required by local policy.	
	Fire safety requirements in SDS and on the PACU were met.	
	Environmental safety requirements in SDS and on the PACU were met.	
	SDS medical laser safety requirements were met.	
	Infection prevention requirements in SDS and on the PACU were met.	
	Medication safety and security requirements in SDS and on the PACU were met.	
	Auditory privacy requirements in SDS and on the PACU were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Eye Clinic	
X	Designated eye clinic employees received laser safety training with the frequency required by local policy.	• Four of the five eye clinic employees did not receive laser safety training within the past 2 years.
	Environmental safety requirements in the eye clinic were met.	
	Infection prevention requirements in the eye clinic were met.	

NM	Areas Reviewed for Eye Clinic (continued)	Findings
	Medication safety and security requirements in the eye clinic were met.	
	Laser safety requirements in the eye clinic were met.	
	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 oxygen tanks on the 3C surgical, 5B medical, and 4A telemetry units are stored in a manner that distinguishes between empty and full tanks and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that soiled utility rooms on the 5A medical, east and central community living center, and medical and surgical intensive care units are locked and that compliance be monitored.

5. We recommended that processes be strengthened to ensure that community living center doors are secured after hours and that compliance be monitored.

6. We recommended that processes be strengthened to ensure crash carts inspections on the dialysis and locked mental health units include the defibrillators and are documented and that compliance be monitored.

7. We recommended that processes be strengthened to ensure that all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that all designated eye clinic employees receive eye laser safety training every 2 years and that compliance be monitored.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[c]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 25 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. 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.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 33 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	• Eight EHRs (24 percent) did not contain documentation that clinicians addressed post-discharge needs related to restricted/special diets or wound care/dressing changes.
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
X	The facility complied with any additional elements required by VHA or local policy.	Local policy on patient treatment plan of care reviewed: • While local policy required discharge plans to be individualized and appropriate to the patient's needs, none of the EHRs contained individualized, patient-specific discharge instructions.

Recommendations

9. We recommended that processes be strengthened to ensure that clinicians identify post-discharge needs and include them in discharge planning.

10. We recommended that processes be strengthened to ensure that clinicians provide individualized, patient-specific discharge instructions.

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[e]

We reviewed relevant documents, the EHRs of 37 randomly selected patients who experienced stroke symptoms, and 15 employee training records (5 emergency department, 5 intensive care unit, and 5 critical care unit), and we conversed with key employees. We also conducted onsite inspections of the emergency department, two critical care units, and five acute care inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility's stroke policy/plan/guideline addressed all required items.	
	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	
	Clinicians provided medication (tPA) timely to halt the stroke and included all required steps, and tPA was in stock or available within 15 minutes.	
X	Stroke guidelines were posted in all areas where patients may present with stroke symptoms.	• Stroke guidelines were not posted on one critical care unit and four acute care inpatient units.
	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	
	Clinicians provided printed stroke education to patients upon discharge.	
	The facility provided training to staff involved in assessing and treating stroke patients.	
X	The facility collected and reported required data related to stroke care.	• There was no evidence that the following data were reported to VHA: o Percent of eligible patients given tPA o Percent of patients with stroke symptoms who had the stroke scale completed o Percent of patients screened for difficulty swallowing before oral intake
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

11. We recommended that stroke guidelines be posted on the medical intensive care; 5B medical; and east, central, and west CLC units.

12. We recommended that the facility report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether the facility provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[f]

We reviewed 11 EHRs of residents (10 residents receiving restorative nursing services and 1 resident not receiving restorative nursing services but a candidate for services). We also observed 2 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In 8 of the 10 applicable EHRs, there was inconsistent documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
X	Care planned/ordered assistive eating devices were provided to residents at meal times.	• Three of the five assistive eating devices care planned/ordered were not provided to residents.
	Required activities were performed during resident meal periods.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that processes be strengthened to ensure that staff consistently complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

14. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[g]

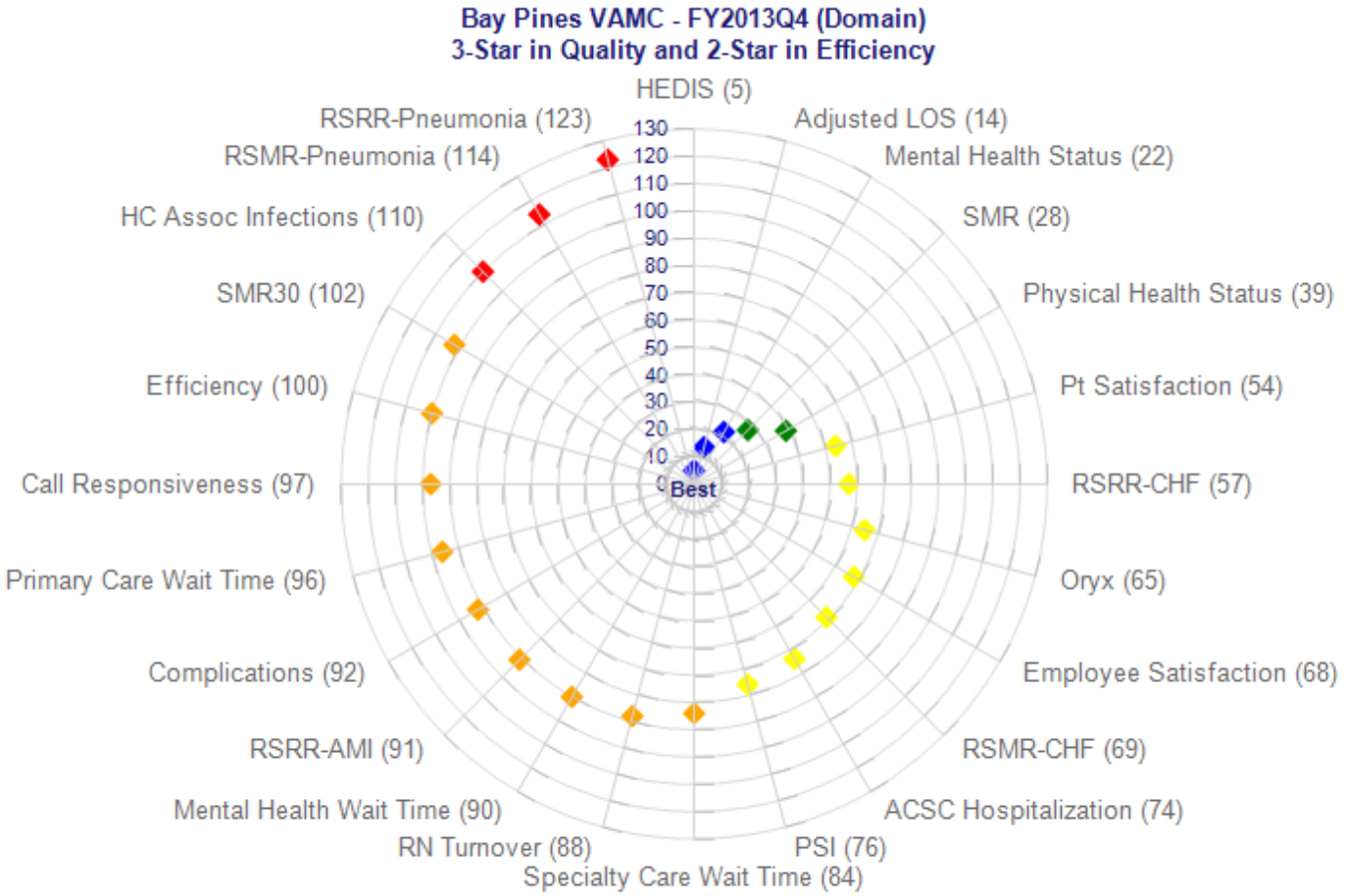
We reviewed relevant documents and the training records of 44 employees (24 randomly selected Level 1 ancillary staff and 20 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted physical inspections of three MRI areas. 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.

NM	Areas Reviewed	Findings
	The facility completed an MRI risk assessment, there were documented procedures for handling emergencies in MRI, and emergency drills were conducted in the MRI area.	
	Two patient safety screenings were conducted prior to MRI, and the secondary patient safety screening form was signed by the patient, family member, or caregiver and reviewed and signed by a Level 2 MRI personnel.	
	Any MRI contraindications were noted on the secondary patient safety screening form, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	
	Level 1 ancillary staff and Level 2 MRI personnel were designated and received level-specific annual MRI safety training.	
	Signage and barriers were in place to prevent unauthorized or accidental access to Zones III and IV.	
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the two-way communication device was regularly tested.	
	Patients were offered MRI-safe hearing protection for use during the scan.	
	The facility had only MRI-safe or compatible equipment in Zones III and IV, or the equipment was appropriately protected from the magnet.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Bay Pines/516) FY 2014 through May 2014[1]	
Type of Organization	Secondary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$625.5
Number of:	
• **Unique Patients**	92,597
• **Outpatient Visits**	911,540
• **Unique Employees**[2]	3,239
Type and Number of Operating Beds:	
• **Hospital**	186
• **CLC**	112
• **MH**	99
Average Daily Census:	
• **Hospital**	143
• **CLC**	96
• **MH**	88
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Lee County/516BZ Sarasota/516GA St. Petersburg/516GB Palm Harbor/516GC Bradenton/516GD Port Charlotte/516GE Naples/516GF Sebring/516GH
VISN Number	8

[1] All data is for FY 2014 through May 2014.
[2] Unique employees involved in direct medical care (cost center 8200).

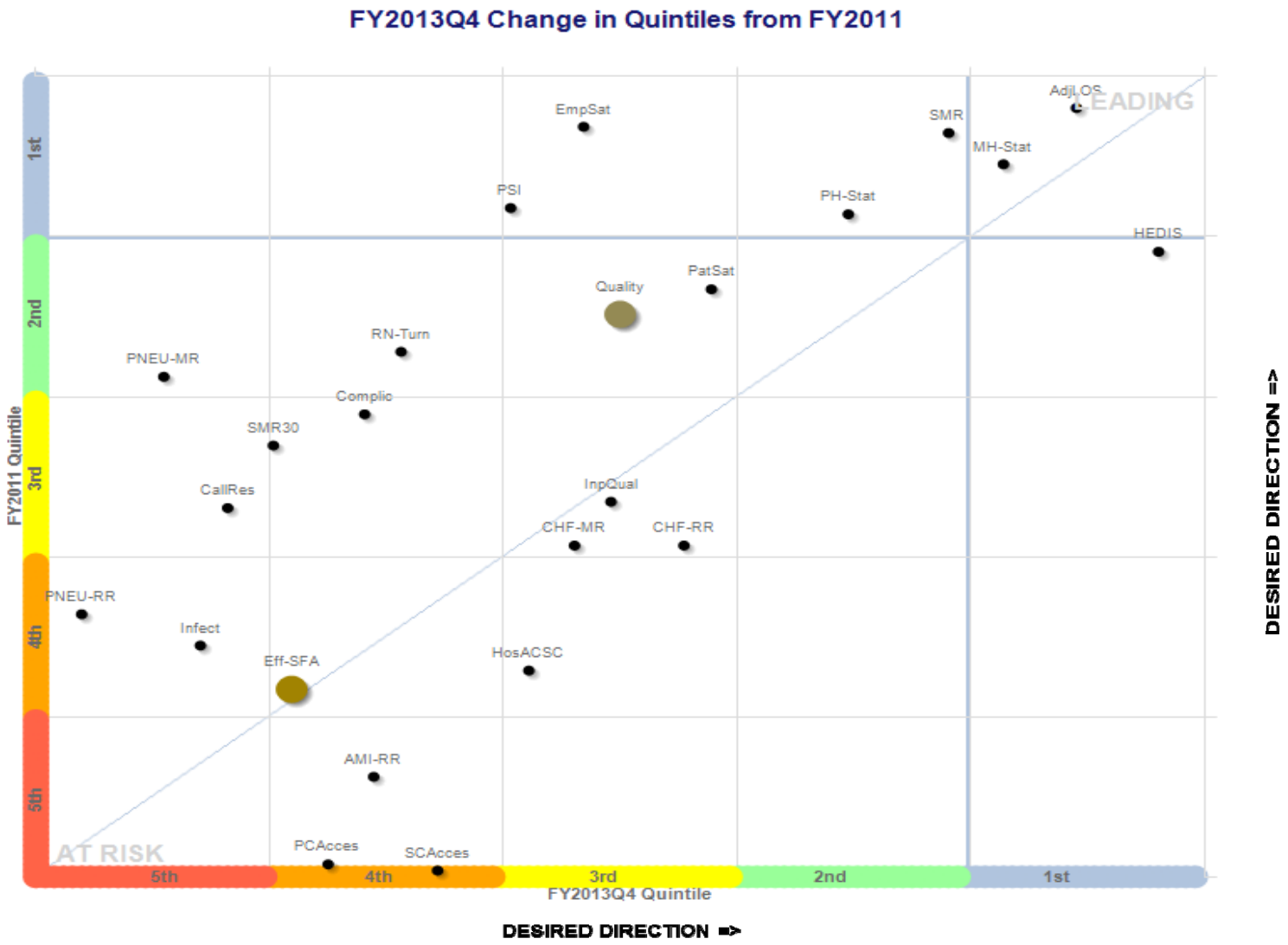
Strategic Analytics for Improvement and Learning (SAIL)[3]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 2, 2014

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

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

To: Director, Washington, DC, Office of Healthcare Inspections (54DC)

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 CAP Review of the Bay Pines VA Healthcare System.

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

(original signed by:)
Joleen Clark, MBA, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 17, 2014

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

Subject: **CAP Review of the Bay Pines VA Healthcare System, Bay Pines, 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. I appreciate the opportunity for this review as a continuing process to improve the care to Veterans. Thank you.

(original signed by:)
SUZANNE M. KLINKER

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the review of electronic health record quality includes most services.

Concur

Target date for completion: 08/30/14

Facility response: Electronic Health Record (EHR) review process, tools and reporting requirements for Geriatrics and Extended Care (GEC) and Primary Care (PC) services will be updated and implemented to ensure compliance with VHA and current facility health record review practice. Applicable GEC and PC staff will be educated on the EHR quality review, reporting requirements and updated processes and tools by August 2014. Quarterly reviews will be submitted and analyzed by the Medical Record Subcommittee during the next identified clinical service quarterly reporting cycle that follows August 2014 and reported to the Information and Data Management Committee.

Recommendation 2. We recommended that processes be strengthened to ensure that the Blood Usage Review Committee member from Surgery Service consistently attends meetings.

Concur

Target date for completion: 07/30/14

Facility response: Designated primary and backup members from Surgery Service have been identified to attend the Blood Usage Review Committee (BURC). The BURC meets quarterly and the surgical service primary representative and will attend the meeting starting July 2014. Compliance with attendance will be monitored by Surgery Service via review of committee minutes (attendance sheet) and documented on the Ongoing Professional Practice Evaluation (OPPE) for the primary provider assigned. The Surgery Service participation and attendance will be reported to the Medical Executive Council.

Recommendation 3. We recommended that processes be strengthened to ensure that oxygen tanks on the 3C surgical, 5B medical, and the 4A telemetry units are stored in a manner that distinguishes between empty and full tanks and that compliance be monitored.

Concur

Target date for completion: 07/30/14

Facility response: The Safety Manager will review each location, 3 C, 5 B and 4 A, to ensure oxygen tanks are stored to distinguish between empty and full and to provide additional storage systems, and signage as needed. Clinical staff in each location will receive education regarding the proper storage and handling of portable oxygen tanks. Respiratory Therapy and Logistics staff will receive education regarding delivery, storage levels and removal of empty tanks. Compliance will continue to be monitored during Environment of Care rounds and reported to Environment of Care Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that soiled utility rooms on the 5A medical, east and central community living center, and medical and surgical intensive care units are locked and that compliance be monitored.

Concur

Target date for completion: 7/30/14

Facility response: The identified soiled utility room doors and locks will be installed in July 2014 and upon installment, staff will be educated on the use of the locks. The locks are self-locking therefore the doors are always locked. Compliance will be monitored during Environment of Care rounds and reported to Environment of Care Committee.

Recommendation 5. We recommended that processes be strengthened to ensure that community living center doors are secured after hours and that compliance be monitored.

Concur

Target date for completion: 08/15/14

Facility response: The Community Living Center (CLC) doors leading to the two smoking porches cannot be automatically secured at this time due the ongoing Security System Upgrade Project (Minor Construction Project) and the potential for violation of National Fire Protection Association (NFPA) Life Safety Code, section 19.2, Means of Egress Requirements and Chapter 7 Means of Egress. Therefore, the following interim Security measures will be taken.

1. CLC staff members will continue to be vigilant in their monitoring of all persons in CLC who are not CLC Residents and/or who are not identified with an official VA Identification Badge.
2. Police will continue their foot patrols throughout the CLC a minimum of once every two hours between the hours of 9:00 PM and 5:00 AM; more frequent foot patrols will occur depending on the volume of other police incidents occurring elsewhere on campus.
3. Eight (8) CLC video cameras located on the porch and two (2) are located in the rear door entry of the porch will be monitored 24/7 by police operations.
4. All observations of access into the CLC via the smoking porches by individuals other than CLC Residents or VA staff will require an immediate response by Police Service to the designated CLC areas.
5. Validation of CLC staff awareness, as well as the monitoring of Police foot patrols, will be reported at the monthly Environment of Care Committee scheduled for July 16, 2014.

The above interim security measures will be undertaken until such time that the CLC doors can be physically secured without violation of life safety codes. Engineering estimates the work to be performed to modify the existing doors and locking mechanisms can be completed by August 15, 2014; this will provide for the manual locking of CLC doors and require that Interim Life Safety Measures (ILSM) are instituted. It is important to note that within the 30 day time frame, it is likely that the Security System Upgrade Project (Minor Construction Project) may actually be in Final Acceptance phase. If this occurs, then BPVAHCS will proceed with the necessary security system modifications that would provide for electronic locking and emergency release functions that fully comply with NFPA Life Safety Codes.

Recommendation 6. We recommended that processes be strengthened to ensure crash carts inspections on the dialysis and locked mental health units include the defibrillators and are documented and that compliance be monitored.

Concur

Target date for completion: 10/01/14

Facility response: Nursing staff has completed training on the code cart checks and defibrillators. Nursing Service has initiated weekly (random) spot checks of each defibrillator in the dialysis and psychiatry units to validate that staff are checking the defibrillators, with June 2014 compliance at 100%. The nurse managers will generate a report to their Chief Nurse for each area and it will be presented at the weekly Nursing Operations meeting. This item will be monitored until (3) consecutive months of 90% compliance are achieved.

Recommendation 7. We recommended that processes be strengthened to ensure that all designated same day surgery and post-anesthesia care unit employees receive bloodborne pathogens training annually and that compliance be monitored.

Concur

Target date for completion: 06/17/14

Facility response: As of June 17, 2014, all Ambulatory Surgery Unit (ASU) and Post-Anesthesia Care Unit (PACU) staff identified during the review has completed the required blood borne pathogen training, TMS course item VA 1722107 "Infection Control Update-Strategies for Prevention." The Chief of ASU and PACU and the Chief, EMS will continue to monitor staff TMS compliance with deficiency reports to ensure annual blood borne pathogen training.

Recommendation 8. We recommended that processes be strengthened to ensure that all designated eye clinic employees receive eye laser safety training every 2 years and that compliance be monitored.

Concur

Target date for completion: 05/16/14

Facility response: The Biomedical Equipment Specialist conducted laser safety training for all five providers in April 2014 with 100% compliance. The attendance roster was identified as a "meeting" and not "training." Surgery Service will collaborate with Biomedical Engineering when training is provided and obtain attendance roster. For tracking purposes, a self-certification in TMS will be used for all Laser Safety Training effective immediately. The providers will then self-certify in TMS that training has been completed.

Recommendation 9. We recommended that processes be strengthened to ensure that clinicians identify post-discharge needs and include them in discharge planning.

Concur

Target date for completion: 08/01/14

Facility response: Discharge instruction processes are being updated to ensure patients' identified post-discharge needs are included and communicated in discharge planning. Hand off communication process is being strengthened to include inpatient and PACT team representatives to provide patient specific instructions for post-discharge care. All applicable inpatient and PACT team representatives will be educated on the updated discharge planning processes and post-discharge follow up care by July 31, 2014.

Recommendation 10. We recommended that processes be strengthened to ensure that clinicians provide individualized, patient-specific discharge instructions.

Concur

Target date for completion: 11/01/14

Facility response: Discharge instructions templates are being updated to include all services and patient specific recommendations as per VAHCS Memorandum 516-09-00-003. All applicable inpatient staff will be educated on the updated discharge planning processes, discharge instruction requirements and facility policies, and the revised templates by August 31, 2014.

Compliance with requirements for individualized discharge instructions will be monitored by reviewing at least 30 electronic health records, from 30 randomly selected unique patients. Monthly audits will continue until greater than 90% compliance is sustained and then will be completed randomly thereafter. Monthly auditing results will be reported to the Medical Executive Council.

Recommendation 11. We recommended that stroke guidelines be posted on the medical intensive care; 5B medical; and east, central, and west CLC units.

Concur

Target date for completion: 06/13/14

Facility response: As of June 13, 2014, the stroke guidelines have been posted to all units within the facility. The Stroke Subcommittee will annually review the guidelines and assess each area to assure continued compliance with the availability of stroke guidelines posted to each unit.

Recommendation 12. We recommended that the facility report to VHA the percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral intake.

Concur

Target date for completion: 08/30/14

Facility response: Clarification of “reported to VHA” was provided by the inspector to include reporting to any committees. On July 2, 2014, the Chief of Neurology presented a charter to the Clinical Practice Committee to formalize the Stroke Subcommittee. Effective August 2014, and ongoing quarterly, the Chair of the Stroke Subcommittee will present stroke data including percent of eligible patients given tissue plasminogen activator, the percent of patients with stroke symptoms who had the stroke scale completed, and the percent of patients screened for difficulty swallowing before oral

intake and include pertinent findings, goals, action plans, to the Clinical Practice Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that staff consistently complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: 10/01/14

Facility response: All Community Living Care Center Staff will be re-educated on the need for documentation of restorative care as indicated on the care plan. A minimum of weekly documentation will be completed indicating the number of minutes and frequency of restorative care delivered. Compliance audits will be maintained at 90% for three months and then will be conducted randomly. The Restorative Nurse will monitor compliance monthly and report at the Geriatrics and Extended Care (GEC) Performance Improvement Committee.

Recommendation 14. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: 09/01/14

Facility response: Nutrition and Food Service (NFS) purchased additional scoop plates for the Community Living Center (CLC). The extra scoop plates are now stored in the CLC for use when needed. NFS educated staff members and implemented an assistive feeding devices tray accuracy monitor. NFS will check the individual tray against the tray ticket to determine that the assistive feeding devices are required on the tray. As of May 2014, NFS have checked CLC at 5 different meals with 100% accuracy on assistive feeding devices. This item will be monitored until three (3) consecutive months to assure 100% compliance.

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Endnotes

[a] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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- VHA Directive 2009-005, *Transfusion Utilization Committee and Program*, February 9, 2009.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

[b] References used for this topic included:
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- VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.
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- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the American National Standards Institute/Advancing Safety in Medical Technology, the Centers for Disease Control and Prevention, the International Association of Healthcare Central Service Materiel Management ,the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
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- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Manufacturer's instructions for Cipro® and Levaquin®.
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[d] References used for this topic included:
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- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
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[e] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[f] References used for this topic included:
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- Various requirements of The Joint Commission.

[g] References used for this topic included:

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