Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, Florida

Report No. 06-02004-14 **October 25, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of May 15–19, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the James A. Haley VA Medical Center (the medical center), Tampa, Florida. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and awareness training to 503 employees. In addition, we followed up on selected recommendations made in a 2003 CAP report of the medical center.

Results of Review

The CAP review focused on eight areas. The medical center complied with selected standards in the following five areas:

- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications
- All Employee Survey
- Patient Satisfaction
- Contract Community Nursing Home Program

We identified conditions in QM, Environment of Care, and Diagnostic Support Services that needed management attention. The following recommendations were made:

- Improve Root Cause Analysis (RCA) action and outcome measure tracking.
- Ensure timely post-operative report documentation.
- Ensure monitoring of crash cart and defibrillator testing and documentation.
- Ensure unattended hazardous cleaning supplies are secured.
- Ensure inspection and replacement of medication refrigerators, as needed.
- Ensure radiology images are interpreted in accordance with Veterans Health Administration (VHA) timeliness standards.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors concurred with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 13–19 for the full text of the Directors' comments.) We will follow up on planned improvement actions.

(original signed by:)
JOHN D. DAIGH, Jr., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics (CBOCs) located in Brooksville, Kissimmee, Lakeland, Sanford, and Zephyrhills. Additionally, three multi-specialty outpatient clinics serve veterans in Orlando, Brevard, and New Port Richey. The Orlando outpatient clinic includes a Nursing Home Care Unit (NHCU) and a Domiciliary. The medical center is part of VA Sunshine Healthcare Network (VISN) 8 and serves a veteran population of about 435,442 in a primary service area that includes 7 counties in central Florida.

Programs. The medical center provides medical, surgical, mental health, geriatric, rehabilitation, ambulatory, home-based primary care, and spinal cord injury services. The medical center has 320 hospital beds and 264 nursing home beds and operates several regional referral and treatment programs, including Radiation Oncology, Spinal Cord Injury, and Cardiothoracic Surgery. The medical center also has sharing agreements with the University of South Florida College of Medicine and affiliated hospitals, and is one of four national VA Polytrauma Centers receiving active duty patients.

Affiliations and Research. The medical center supports 135 medical resident positions in 27 specialties. There are approximately 80 associated health affiliations. In fiscal year (FY) 2005, the medical center research program had 185 projects and a budget of $4.3 million. Important areas of research include diabetes, Parkinson's Disease, and Alzheimer's Disease. The medical center also has a Patient Safety Center of Inquiry.

Resources. In FY 2005, medical care expenditures totaled over $524 million. The FY 2006 medical care budget is $551 million. FY 2005 staffing totaled 4,036 full-time equivalent employees (FTE), including 266 physician and 745 nursing FTE.

Workload. In FY 2005, the medical center treated 133,767 unique patients. The medical center provided 92,085 inpatient days of care in the hospital and 89,715 inpatient days of care in the NHCU. The inpatient care workload totaled 11,625 discharges, and the average daily census was 520, including NHCU patients. The outpatient workload was 1,523,544 visits.

Objectives and Scope of the CAP Review

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 program are to:

- Conduct recurring evaluations of selected health care facilities focusing on patient care and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review (*Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, Florida*, Report No. 02-03094-101, May 22, 2003).

In performing the review, we inspected work areas, interviewed managers, employees and patients, and reviewed clinical and administrative records. The review covered selected aspects of the following programs and activities:

All Employee Survey	Environment of Care
Breast Cancer Management	Patient Satisfaction
Contract Nursing Home Program	Quality Management
Diabetes and Atypical Antipsychotic Medications	Diagnostic Support Services

The review covered medical center operations for FY 2005 and FY 2006 through May 19, 2006, and was completed in accordance with OIG standard operating procedures for CAP reviews.

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.

Results of Review

Opportunities for Improvement

Quality Management – Root Cause Analysis Follow-Up and Post-Operative Documentation Needed Improvement

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported and appropriately responded to QM efforts; and (c) the medical center was compliant with VHA directives, appropriate accreditation standards, and Federal and local regulations. This review included a self-assessment of the QM program completed by the quality manager and interviews with senior management staff. We reviewed documents related to the functioning of the QM committee, performance improvement teams, mortality analyses, patient complaints, risk management, patient safety, utilization management, medication management, blood products usage, operative and other procedures, outcomes of resuscitation, medical records, restraint and seclusion, and staffing effectiveness standards. With the exception of the following conditions needing improvement, we found that QM processes were effectively monitoring patient care activities.

Conditions Needing Improvement. RCA follow-up actions, as required by VHA, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and medical center policy, were incomplete. In addition, brief post-operative progress notes and dictated operative reports were not immediately available, as required in medical staff bylaws. These conditions could negatively affect patient safety and needed management attention.

RCA Follow-Up Actions. In our 2003 CAP report, we identified that RCA corrective action follow-up needed improvement. The medical center's actions included hiring a new Patient Safety Manager in August 2002 with responsibility for reviewing all RCAs and following up on corrective actions to completion.

However, in our review of all RCAs done during 2005, we found that the problem with RCA corrective action follow-up still existed.

Fiscal Year 2005 RCAs

	Individual	Aggregate[1]	Total
Total RCAs Completed	24	10	34
Total RCAs Reviewed by OIG	13	7	20
Some Action Plan Elements Not Completed	5	5	10
Some Outcome Measures Not Evaluated	11	5	16

[1] Systemic issues.

In 50 percent of the RCAs we reviewed, some element of the action plans had not been completed; in 80 percent of the RCAs, some outcome measures had not been evaluated for effectiveness. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook,* and Hospital Policy Memorandum (HPM) 11-54, *Patient Safety Improvement/Adverse Event Reporting,* require the implementation of action plans designed to prevent future occurrences of similar events and the evaluation of outcome measure effectiveness to ensure that changes have the desired effect. Without implemented action plans and evaluation of outcomes, patient safety effectiveness and improvement cannot be determined.

Post-Operative Documentation. In the May 17, 2006, *Incomplete Medical Records Report,* we found 24 operative reports had not been dictated immediately after the procedure as required in the medical staff bylaws; the oldest surgical case was performed on March 28, 2006. We then determined that the required brief post-operative progress note was not immediately available in the medical record in 19 of 24 cases. The medical staff bylaws require that, "…all operations performed shall be briefly described in the progress notes of the patient's chart immediately after the procedure and, in addition, fully described in an operative report dictated immediately after the surgery." Without the immediate documentation of a brief post-operative progress note and immediate dictation of the operative report, managers cannot be assured that important clinical information is available should post-operative intervention become necessary.

Recommended Improvement Action(s) 1. The VISN Director should ensure the Medical Center Director requires (a) complete implementation of action plans and evaluation of effectiveness for all individual and aggregate RCAs and (b) immediate documentation of brief post-operative progress notes and dictation of operative reports as outlined in medical staff bylaws.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. The Patient Safety Officer will develop an administrative position to provide clerical support and will improve action follow-up and evaluation of outcomes through enhanced filing and computerized tracking systems. The Patient Safety Officer will ensure dictation and documentation of post-operative notes as outlined in medical staff bylaws through increased monitoring and reporting of incomplete reports to the Chief of Staff.

Environment of Care -– Follow-Up to Previously Identified Deficiencies Was Insufficient

To assess the safety and cleanliness of the medical center, we inspected eight patient care wards or units, the Veterans Canteen Service dining room and retail store, selected public areas, and the Food and Nutrition Service. Overall, we found the medical center to be clean and appropriately maintained. Some minor issues such as leaky faucets and dirty sinks in medication rooms, as well as ice machine corrosion, were corrected before we

left the site. Managers provided us with work and purchase orders for other identified issues.

Conditions Needing Improvement. We determined that managers did not follow up on some corrective actions taken in response to patient safety deficiencies identified in our 2003 CAP report. As a result, some conditions had not been adequately resolved. Deficiencies related to crash cart and defibrillator testing, security of hazardous cleaning solutions, and monitoring of medication refrigerators require management attention.

- In our 2003 report, we noted that three crash carts and defibrillators were not properly checked. The medical center's corrective action was to review and revise the policies that addressed both the crash carts and the defibrillators. HPM 11-14, *Cardiopulmonary Resuscitation*, requires the Cardiopulmonary Resuscitation (CPR) Committee to be responsible for "Monitoring of compliance with operational defibrillator testing and documentation." HPM 11-56, *Defibrillator Quality Management*, states that testing must include, among other items, "…output energy, proper functioning of the defibrillator including the chart recorder," and "…documentation of operational tests."

  However, in 2006 we found that the CPR Committee did not meet requirements as outlined in medical center policy, because they did not monitor testing and documentation compliance of crash carts and defibrillators. In fact, we found there was no process in place to do so. During our visit, we found that the defibrillator checklist on NHCU-A had been signed off as tested on the day of our inspection, yet the recording tape still attached to the defibrillator was dated the previous day. Without routine testing, managers could not be assured that this potentially life-saving equipment was functioning properly. The CPR Committee chairman agreed with our conclusions and told us he would address the issue immediately with the CPR Committee.

- In our 2003 report, we noted that 21 housekeeping carts were unattended over a 3-day period. The medical center's corrective action was "…to ensure that environmental management employees receive supplemental training on security of hazardous cleaning supplies and that these supplies be secured in lockable areas on supply carts and in housekeeping aid closets."

  However, in 2006, we found an unattended housekeeping cart with accessible cleaning solutions that could pose a hazard to patients. The Environmental Management Service (EMS) supervisor told us that housekeeping closets are not large enough to accommodate in-use housekeeping carts, and housekeeping employees are permitted to leave carts in the hall during break times after securing any cleaning solutions. JCAHO *Standard EC.1.20* requires hospitals to provide a safe environment and *Standard EC.3.10* addresses the handling of hazardous chemicals from acquisition to storage and disposal. While we were on site, EMS, Safety,

Engineering, and Nursing Services agreed that housekeeping carts could be placed in locked soiled utility rooms while housekeeping employees are on break. Managers provided a copy of the communication sent to all housekeeping supervisors.

- In our 2003 report, we identified that three medication refrigerators were not suitable to maintain medications. The medical center's corrective action was to enforce HPM 137-01, *Environmental Services Responsibilities*, dated October 1999, which states "…contents and temperatures of refrigerators storing medications are checked daily by Nursing Service with weekly cleaning completed by EMS. Daily logs are maintained on all refrigerators. Environmental Safety Monthly Records are maintained. Validation of compliance with the policy is accomplished through Environment of Care rounds."

  However, in 2006, we found no records of monthly safety records, or any mention of compliance in Environment of Care Rounds minutes. On two of the six wards (33 percent) we inspected, medication refrigerators needed attention. The medication refrigerator door on ward 7N did not close properly due to ice build-up, and as a result, was dripping water onto medicine boxes. The medication refrigerator door on ward 2BSW also did not close properly. JCAHO *Standard MM.2.20* requires maintenance of medication integrity. Managers had initiated actions to replace the 7N and 2BSW refrigerators about 2 weeks prior to our inspection. If medication refrigerators are not functioning properly, medications could be unsafe for patient use.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that: (a) crash cart and defibrillator testing and documentation are monitored, (b) hazardous cleaning supplies are secured when unattended, and (c) medication refrigerators are inspected and replaced as necessary.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Nurse Managers have responsibility for verification of crash cart and defibrillator testing. The medical center has designated alternative secure storage areas for unattended housekeeping carts, has plans to purchase medication refrigerators with temperature alarm systems, and has assigned responsibility for scheduled refrigerator temperature checks.

Diagnostic Support Services – Radiology Interpretation and Verification Times Needed Improvement

Timely laboratory and radiology services are critical components in the delivery of quality patient care. We reviewed whether patients had timely access to select tests and exams, and whether results were available to the ordering providers within reasonable timeframes. While we found that laboratory turn-around times were within established timeframes, we determined that some radiology exams were not interpreted and verified in a timely manner.

The Radiology Service offers general x-rays, computerized tomography (CT) scanning, magnetic resonance imaging (MRI), ultrasonography, angiography, interventional radiological procedures, and screening mammography. In FY 2005, Radiology Service completed more than 142,000 examinations.

Conditions Needing Improvement. From January 1 to March 31, 2006, the Tampa and Orlando divisions completed 14,918 CTs, MRIs, ultrasounds, and mammograms; however, radiologists did not consistently interpret and verify those films within 48 hours in accordance with VHA performance measure standards. This measure requires 90 percent of exams to be interpreted within 48 hours.

Selected Radiology Exams
January 1 – March 31, 2006

	Tampa		***Orlando***	
	Total # of exams	Percentage not verified within 48 hours	Total # of exams	Percentage not verified within 48 hours
CT	5,501	21	1,797	35
MRI	2,427	14	391	76
Ultrasound	2,411	31	1,445	36
Mammogram	550	53	396	80

Tampa and Orlando Radiology divisions have different Service chiefs; both told us that inadequate radiologist staffing resulted in untimely interpretation and verification. Both divisions are recruiting radiologists, but the public-private salary differential makes this challenging.

Mammogram interpretation and verification was the largest outlier in both divisions. The Chief of Radiology at the Tampa division told us that radiologists assigned to read mammograms often wait for comparison films from private hospitals before interpreting new films, which can delay the process. He agreed, however, that radiologists could read the mammograms and note in the record that comparison films were not available. The record could later be addended when comparison films were received.

Timely image interpretation and verification allows clinicians to promptly treat conditions that might be identified through radiological exams.

Recommended Improvement Action(s) 3. The VISN Director should ensure the Medical Center Director requires that radiology images be interpreted in accordance with VHA timeliness standards.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. The medical center is addressing the

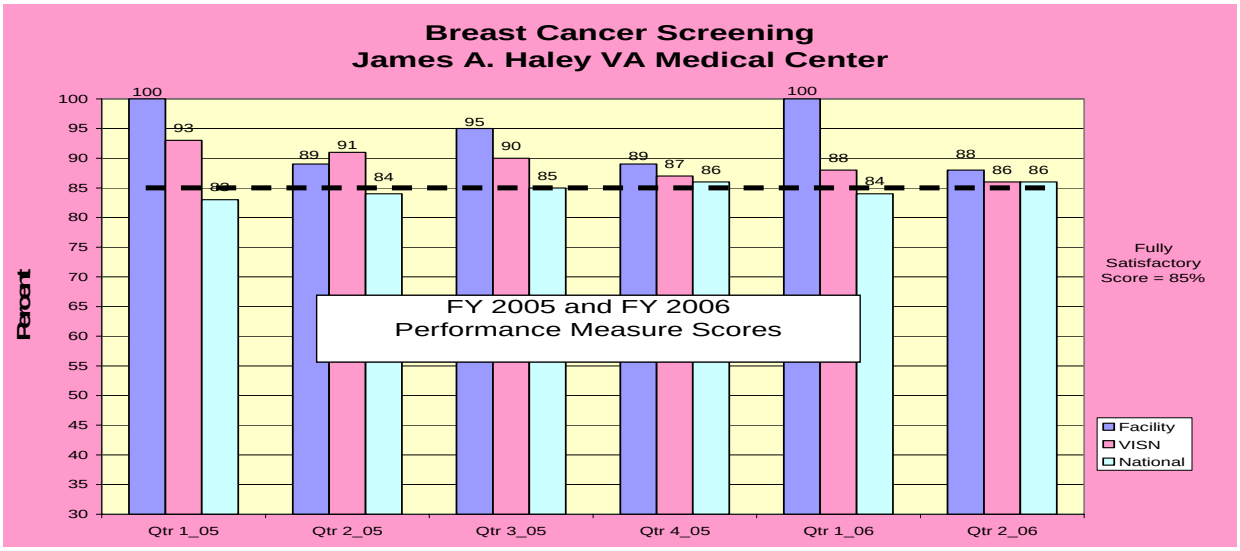
radiology timeliness issues through active recruitment of radiologists to fill vacancies, contracting with local vendors to provide additional radiologist coverage, and enhancing the current PACS[2] system to accommodate teleradiology technology.

Other Focused Review Results

Breast Cancer Management – Patients Are Managed Appropriately

The medical center met the VHA performance measure for breast cancer screening, provided timely Radiology, Surgery, and Oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The following table illustrates the medical center's breast cancer screening performance.



We assessed a random sample of 10 patients diagnosed with breast cancer during FY 2005. Our review found that all eight patients who met criteria for our review had screening mammograms. The patients received timely biopsies, consultations, and treatments. Clinicians communicated well with patients, keeping them informed of test results, and involving them in the treatment planning process. We found patient care was well coordinated from the time of presentation with symptoms (or for screening) to the conclusion of treatment.

[2] Picture Archiving and Communications System (PACS) is a VA-developed computer or network system that uses an image server to exchange X-rays, CT scans, and other medical images over a network. Also known as VistA Imaging, it provides for the display of "image data" with seamless integration with CPRS, which is VA's electronic medical record.

Diabetes and Atypical Antipsychotic Medications – Patients Were Appropriately Screened and Managed

Medical center clinicians performed effective diabetic screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. A normal FBG is less than or equal to 110 mg/dl. Patients with FBG values greater than 110 mg/dl but less than 126 mg/dl should be counseled about prevention strategies (calorie-restricted diets, weight control, and exercise). A FBG value that is greater than or equal to 126 mg/dl on at least two occasions is diagnostic for diabetes.

We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. None of the patients reviewed developed diabetes. The review showed that the medical center followed clinical practice guidelines for screening and monitoring of patients at risk for diabetes.

Psychiatry managers shared a draft policy, HPM 116A-04, *Atypical Antipsychotic Medications*, which includes appropriate management of side effects or metabolic abnormalities that might occur with these medications. The policy is comprehensive and requires that, prior to treating a patient with an atypical psychotropic medication, an initial assessment for diabetes is completed to include baseline weight, blood pressure, fasting glucose, and lipid profiles.[3] The policy will require diabetic assessment at a 3-month follow-up, and every 6 months thereafter.

All Employee Survey – Results Were Used to Enhance Employee Satisfaction

The medical center utilized All Employee Survey (AES) data to improve employee satisfaction. VHA administers an AES every 3 years to assess employee and organizational satisfaction. An Executive Career Field performance plan measure required VISN directors to analyze the employee survey results and develop action plans to address areas in need of improvement by September 30, 2004. The medical center did not submit a plan to VISN 8, although actions were taken.

The medical center employees' response rate was 57.5 percent; more than 7 percentage points higher than the average of the response rates for other VISN 8 facilities. Medical center managers communicated results through Town Hall meetings and postings on the shared computer drive. Although no factors of statistical significance fell below the

[3] A blood test that measures the level of lipids (fats), such as cholesterol and triglycerides, to assess risk of cardiovascular disease.

VISN 8 or national means, medical center managers chartered the Employee Satisfaction Action Team (ESAT) to target lower satisfaction areas. The ESAT, with facilitation from the National Center for Organizational Development, conducted focus groups with more than 300 employees to better understand their specific concerns. The ESAT then developed action plans targeting rewards and recognition, position classification, and upward mobility.

The AES Coordinator, along with the ESAT, has developed a process to analyze and communicate 2006 AES results, work with individual services on action plan development and follow-up, and evaluate the effectiveness of those actions. We made no recommendations because 2004 AES scores were comparable to VISN 8 and national averages, actions were implemented to enhance employee satisfaction, and a system is in place to address the 2006 AES.

Patient Satisfaction – Managers Are Addressing Deficiencies

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas including access to care, coordination of care, and courtesy. VHA relies on the analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients and 76 percent of inpatients discharged during a specified date range will report their experiences as very good or excellent. The following graphs show the medical center's (or clinics's) performance in relation to national and VISN performance. Medical centers are expected to address areas in which they are underperforming. In the following two charts, note that "+" indicates results that are significantly better than the National average and "-" indicates the score is significantly worse than the National average.

Inpatient SHEP Results
Q3 and Q4 FY05

INPATIENT - Q3 and Q4 FY05	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**80.73**	**78.27**	**89.40**	**67.36**	**65.08**	**75.37**	**83.35**	**73.98**	**69.52**
VISN	**77.9-**	**77.60**	**90.10**	**68.00**	**66.10**	**75.30**	**84.10**	**74.30**	**69.30**
Medical Center	77.2-	75.7-	89.50	67.90	66.30	76.30	82.70	72.30	67.50

Outpatient SHEP Results
Q1 FY06

OUTPATIENT - Q1 FY06	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**81.5**	**78**	**95.3**	**73.1**	**83.7**	**76.2**	**82.6**	**66.5**	**82.2**	**80.7**	**85.2**
VISN	**78.1 -**	**83.9 +**	**94.8**	**73.4**	**84.9**	**77.1**	**82.6**	**63.3**	**82.7**	**77.9**	**83.8**
Outpatient Clinics - overall	81	88.9 +	96.7	75.8	87.8 +	78.8	84.2	64.3	82.9	80.6	87.3
TAMPA CLINIC	76.6	89.2 +	97.8	75.3	87.5	77.5	81.5	53	81.7	77.7	86.8
ORLANDO CLINIC	81.5	91 +	95	74.2	86.1	77.4	*	77.1	82.4	80.6	88.9
PASCO CLINIC	82.6	89.6	95.3	78	88.2	79.4	82.7	60.3	83.5	90.3 +	85.9
BREVARD CLINIC	87.2	89.1	97.5	75.7	91.6 +	82.5	92.6	62.2	84.9	86.5	86.3
BARTOW CLINIC	85.8	82.2	97.2	81.2	86.1	79.5	93.9 +	*	87.8	81	90.8
BROOKVILLE CLINIC	91.4 +	91.5 +	98.9 +	85.4 +	92.8 +	87.7 +	85.9	*	89.5 +	79.7	89.8
SANFORD CBOC	94.5 +	67.3	95.6	78.1	84	79.8	90	*	86.2	83.2	90.1
KISSIMMEE CBOC	83.5	82.7	94	71.2	83.8	75.8	85.9	*	83.2	73.1	83.7
ZEPHYRHILLS CBOC	81.1	58.4 -	96	65.9	81.6	76.6	70.5	*	78.5	*	83

** signifies fewer than 30 respondents*

The medical center has a designated Customer Service Coordinator who works with the VISN 8 Customer Service Workgroup to analyze SHEP results. Action plans were developed to address areas needing improvement.

Contract Community Nursing Home Program – Oversight Was Comprehensive

The medical center's CNH Program staff provided appropriate and comprehensive oversight of the community nursing facilities caring for veterans. We reviewed the CNH Program to assess compliance with local and national policies regarding the selection of contract facilities, the review process for contract renewal, and the monitoring of patients in community nursing facilities. We evaluated whether patients received the fee-basis services (speech, physical, or occupational therapy) not included in basic contracted care, whether there were effective processes in place to more closely monitor the community nursing facilities where deficiencies had been identified, and whether patients and family members were sufficiently involved in the placement process and given choices regarding community nursing facility selection.

The medical center currently has 56 veterans under contract care in 38 community nursing facilities located in Tampa and Bay area counties. We selected five community nursing facilities for review and visited two of them. We interviewed the administrator and director of nursing (DON) at these sites. We conducted 10 patient record reviews and interviewed 8 patients and/or a family member.

The CNH Program was well coordinated and complied with local and VHA policy. The CNH Oversight and Review Team committees met regularly to discuss inspection results

and contract renewal recommendations. CNH review teams utilized the exclusion report (which summarizes quality indicators and results of state and other inspections) to pass or fail a facility, or to recommend increased monitoring, holds on admissions, or contract termination. Although not required by policy, the CNH review teams conducted annual reviews even when the exclusion report did not indicate a need.

We found that families were involved in the community nursing facility selection process, given choices when available, and their preferences were accommodated when possible. Families and community nursing facility staff told us, and we confirmed by medical record review, that CNH Program staff visited frequently (more than required by policy). The administrators, DONs, and families told us that CNH Program staff were accessible and responsive to their needs and concerns. We also confirmed that patients received services as ordered.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2006

From: Director, VA Sunshine Network (10N8)

Subject: **Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, Florida, Project Number 2006-02004-HI-0343**

To: Director, Management Review Office (10B5)

1. Thank you for the opportunity to review the draft report of the Combined Assessment Program Review for the James A. Haley VA Medical Center, Tampa, Florida.

2. I have reviewed the report and concur with the recommendations made by the Office of Inspector General. I concur with the actions planned and taken by the Medical Center and appreciate their continued efforts to provide our Veterans with timely access to high quality healthcare.

3. If you have any questions please contact Karen Maudlin (727) 319-1063.

(original signed by:)
George H. Gray, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 3, 2006

From: Director, James A. Haley VA Medical Center (673/00)

Subject: **Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, Florida, Report Number 2006-02004-HI-0343**

To: VISN 8 Network Director (10N8)

[OIG comment – see pages 15–19 for action plans]

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendation(s)

Recommendation 1. The VISN Director should ensure the Medical Center Director requires:

a**.** Complete implementation of action plans and evaluation of outcome measure effectiveness for all individual and aggregate RCAs.

Concur **Target Completion Date:** 10/1/06

The Patient Safety Manager is taking the following actions to improve implementation and evaluation of RCA action plans:

1. Develop a position for a Patient Safety/Risk Management Program Assistant to provide clerical Support to the Patient Safety Manager.

2. Use five part folders for RCA's that include a specific section for documentation of actions completed and outcome measures.

3. Develop a computerized tracking program for actions and outcomes that are due with memos sent when an action item or measure is due.

4. RCA action memos will include a tracking report form that will detail actions to be completed, date due and outcome measures required. The recipient will be required to sign an attestation statement when that action is completed. The documentation of completed actions will be included in the RCA file.

5. All RCA correspondence will be hand carried with a distinctive file cover.

6. Risk Management Committee will act upon any actions or outcome measures that have not been documented by the date required. RCA actions and outcomes will be tracked until completion. Minutes will reflect these delinquent actions and results.

b. Immediate documentation of brief post-operative progress notes and dictation of operative reports as outlined in medical staff bylaws.

Concur **Target Completion Date:** 8/11/06

The following actions will be taken to improve compliance and consistency with the dictation of operative reports.

1. Develop and implement a point of care and concurrent medical record review of all operative patients until sure that there is consistency in having the completed brief operative report before the surgeon leaves the recovery area.

2. Require the dictation job number be documented in the brief operative note so immediate verification that the operative report was dictated is apparent.

3. Monitor completion of all operative reports weekly with corrective action for each report not completed and signed within one work week.

4. Quality Management to perform a retrospective review of operative cases with a summary of compliance sent to the Chief of Staff weekly.

Recommendation 2. The VISN Director should ensure that the Medical Center Director requires that:

a. Crash cart and defibrillator testing and documentation are monitored.

Concur **Target Completion Date:** 8/1/06

1. Each Nurse Manager is to assign the responsibility for code cart and defibrillator testing on a scheduled basis. Each Nurse Manager will report to the responsible Associate Chief Nursing Service (ACNS) on a monthly basis the status of the completion of code cart and defibrillator checks (also includes AEDs). This is an ALL or NONE item. Each day of the log should have an entry. If the unit is closed, then a note to that effect will be entered. If any day the unit is open and a check is not done then we are noncompliant and the unit scores a 0 for that month. If ALL checks for every day are documented then the score is 100%. A score of 0 for any item is unacceptable. The ACNS will submit this report to the ACOS/Nursing each month (signed and dated). This provides responsibility and accountability across all levels of the service with reporting of the Quality Control checks on these carts and equipment.

2. The Nurse Manager will be required to fax a copy of the completed monthly log to the Quality Management Office.

b. Hazardous cleaning supplies are secured when unattended.

Concur **Target Completion Date:** 4/06

1. The housekeeping carts are to be stored in the soiled utility closet while employees go on break or lunch. They are to be placed against the wall not obstructing anything in the room. At the end of the shift, all carts will be stored in their closet and will not be stored in the utility closets overnight.

c. Medication refrigerators are inspected and replaced as necessary.

Concur **Target Completion Date:** 12/06

1. The medication refrigerators for individual nursing units have been identified by the ACOS/Nursing and a purchase will be made. The model will have the ability to digitally display the current core temperature with the ability to alarm if the temperature exceeds a range programmed into the system to match our policy. Any variances from the range will alarm so the staff can respond by a) notifying Engineering and b) consulting with pharmacy on safety of medications exposed to out of range temperatures.

2. Each Nurse Manger is to assign the responsibility for refrigerator checking on a scheduled basis. Using the current Hospital Policy Memorandum (HPM) guidance and log, each Nurse Manager is to report to the responsible ACNS on a monthly basis the status of the completion of refrigerator checks. This is an ALL or NONE item. Each day of the log should have an entry. If the unit is closed, then a method for monitoring during the closed time period is required. If any day the unit is open and a check is not done then we are non compliant and unit scores 0 for that month. If ALL checks for every day are documented then a score is 100%. If a temperature exceeds the appropriate range and corrective action was taken and noted the unit scores 100. The ACNS will submit this report to the ACOS/Nursing each month (signed and dated). This provides responsibility and accountability across all levels of the service with reporting of the Quality Control checks on this equipment.

Recommendation 3. The VISN Director should ensure the Medical Center Director requires that radiology images be interpreted in accordance with VHA timeliness standards.

Concur **Target Completion Date:** 12/06

The following actions are being implemented to improve timeliness of radiology interpretations.

1. Tampa is actively recruiting radiologists (6 vacancies). One position filled week of 7/31/06, second one scheduled near future, with three being interviewed. Office space is an issue with a plan to remove non essential imaging equipment to provide additional space. Open until position is filled

2. Working on a contract with a Teleradiology company which already serves the Bay Pines and West Palm Beach VAMC's. This will allow for final attending radiologist readings on a 24/7 basis. 12/06

3. Two recently graduated residents (and one pending) have been credentialed to help with the reading of imaging studies after 4:30pm and on week-ends. 8/06

4. Continue with University Diagnostic Institute to help read imaging studies and perform and read some CT and MRI examinations. Also increasing the reading time of our fee basis radiologists as needed. Already implemented

5. The new software version of the PACS system will allow Teleradiology through cable internet. Two of Tampa's radiologists are interested in reading images from home. 11/06

Appendix C

OIG Contact and Staff Acknowledgments

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Acknowledgments	Toni Woodard, Healthcare Inspections Team Leader Bertie Clarke Patrick Crockett Christa Sisterhen Susan Zarter

Appendix D

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