Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03090-160

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

July 1, 2009

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide 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 March 2–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the James A. Haley Veterans' Hospital (the medical center), Tampa, FL. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 574 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 8.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strength:

- Transforming Care at the Bedside (TCAB).

We made recommendations in six of the activities reviewed. For these activities, the medical center needed to ensure that:

- Floors and air ventilation outlets are cleaned routinely.
- Construction barriers remain sealed and staff do not enter construction zones.
- Clean equipment and contaminated equipment are clearly identified and stored separately.
- Safety hazards on the locked mental health (MH) unit are corrected.
- Nurses comply with local policy regarding appropriate labeling of multi-dose medication vials.
- Security of confidential patient information is maintained.
- Patient privacy is maintained.
- Documentation of safety plans for patients deemed at high risk for suicide complies with Veterans Health Administration (VHA) regulations.
- The affiliate university shares results of mortality and morbidity (M&M) reviews on VA patients with the Peer Review Committee (PRC).
- Designated staff complete life support training and a system is put in place to monitor compliance.

- Effectiveness of PRN (as needed) pain medication is documented in the electronic medical record (EMR) within the timeframe required by local policy.
- Transfer documentation is completed in accordance with VHA policy.
- Nursing managers validate that contract/agency registered nurses (RNs) have completed mandatory training and presented evidence of clinical competence and have documentation of completed background investigations prior to providing patient care.

The medical center complied with selected standards in the following two activities:

- Coordination of Care (COC).
- Patient Satisfaction.

This report was prepared under the direction of Carol Torczon, Associate Director, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–23, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

(original signed by:)

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

Introduction

Profile

Organization. The medical center is a tertiary care facility located in Tampa, FL, that provides a broad range of inpatient and outpatient health care services. It has four community based outpatient clinics (CBOCs) located in New Port Richey, Brooksville, Lakeland, and Zephyrhills, FL. The medical center is part of VISN 8 and serves a veteran population of about 177,400 throughout central Florida.

Programs. The medical center provides medical, surgical, primary care, MH, long-term care, and rehabilitation services. It has 415 hospital beds and 118 community living center (CLC)[1] beds.

Affiliations and Research. The medical center is affiliated with 130 university and college programs. It provides training for 166 medical residents and for students in several other disciplines. In fiscal year (FY) 2008, the medical center research program had 207 active projects and a budget of $6.7 million. Non-VA research funding totaled about $10.2 million. Important areas of research included endocrinology, cardiology, surgery, and gastroenterology.

Resources. In FY 2008, medical care expenditures totaled $645 million. FY 2008 staffing was 3,830 full-time employee equivalents (FTE), including 273 physician and 777 nursing FTE.

Workload. In FY 2008, the medical center treated 112,487 unique patients and provided 101,788 inpatient days in the hospital and 34,494 inpatient days in the CLC. The inpatient care workload totaled 12,600 discharges, and the average daily census, including CLC patients, was 372. Outpatient workload totaled 926,558 visits.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

[1] A CLC (formerly called a nursing home care unit) provides a home-like environment to eligible veterans who require a nursing home level of care.

- 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 patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Contract/Agency RNs.
- COC.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered medical center operations for FY 2007, FY 2008, and FY 2009 through February 25, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, Florida*, Report No. 06-02004-14, October 25, 2006). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings to 574 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.

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. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Organizational Strength

Transforming Care at the Bedside

TCAB is an initiative of the Institute for Healthcare Improvement (IHI),[2] in partnership with the Robert Wood Johnson Foundation (RWJF),[3] to improve care on hospital medical/surgical units. This patient care model focuses on nurses as caregivers and seeks to reduce non-clinical demands and system inefficiencies. The initiative requires a team of frontline workers to make significant changes in care processes. The medical center implemented the TCAB initiative on all medical/surgical units and has demonstrated enhanced patient care services and increased staff satisfaction. In 2005, the medical center received the VHA Office of Nursing Services Innovations Award for their efforts in this initiative.

To further improve care processes under the TCAB initiative, the medical center instituted the use of the Vocera® hands-free communication device. The Vocera® device is a badge worn by nursing staff that allows for hands-free wireless communication in any environment. Staff spend less time searching for co-workers to assist them and can remain at the bedside and continue to provide patient care while communicating with other staff. The Vocera® device helps to increase staff productivity and customer satisfaction without incurring ongoing wireless service fees or other telecommunications costs.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine if the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, National Center for

[2] The IHI is an independent, not-for-profit organization that is helping to lead the improvement of health care throughout the world.
[3] The RWJF is an independent philanthropic organization devoted to improving health care policy and practice.

Patient Safety, Occupational Safety and Health Administration, and Joint Commission (JC) standards.

We inspected the acute inpatient units on 4S, 6S, and 7N; the medical intensive care unit; the surgical intensive care unit (SICU); and the post-anesthesia care unit (PACU). We also inspected the locked MH unit, the CLC, the dialysis unit, the emergency department (ED), and the spinal cord injury (SCI) unit. We found that the infection control program monitored exposures and reported data to clinicians for implementation of quality improvements. However, we identified the following conditions that needed improvement.

Environmental Cleanliness. Managers did not ensure that floors and ventilation outlets were routinely cleaned. We found floors in need of deep cleaning (stripping, cleaning, and waxing), and we found dust in air ventilation outlets in several of the inpatient units and public bathrooms. While we were onsite, managers provided an action plan that included routine cleaning and inspection of floors and air ventilation outlets and monthly reporting of inspection results to the EOC committee.

Infection Control. We found an unsealed construction barrier inside a room on the neurology unit. In addition, the door to the room was propped open. Staff told us that they were entering the construction zone to connect an electroencephalography (EEG) machine to an outlet so that EEG procedures could be performed in an adjacent room.

We found dirty and clean gastrointestinal endoscopes stored in the same room. The nurse manager told us that space was inadequate due to renovations on that unit. Although lack of adequate space was clearly an issue, contaminated equipment should be identified and stored separately from clean equipment to avoid risk of infection.

Patient Safety. We found several potential safety hazards on the locked MH unit.

- A television cord in the dayroom exceeded the 12-inch limit.
- Chairs, tables, and a television in the dayroom were light enough to be lifted and were not secured.
- A bathroom that was not completely free of safety hazards was unlocked and propped open.

Multi-dose medication vials on 7N, 4N, and the CLC were opened but not dated, and one on the SCI unit was outdated. While we were onsite, managers provided an action plan to communicate and reinforce local policy to all nursing staff.

Information Security and Patient Privacy. We found computers logged on but left unattended on 5S and in the ED. Also, we found a lack of patient privacy in the pre-admission screening, pre-operative, and PACU areas and in the chemotherapy/oncology infusion clinic. In the pre-admission screening area, we found five desks in a relatively small area that were not separated by partitions. Staff told us that discussions involving personal information could be heard by others in the area. Additionally, patient care areas in the pre-operative unit, the PACU, and the chemotherapy/oncology infusion clinic were not separated by curtains, and partitions were not available to provide privacy for patients, if needed. Managers told us that there were plans to relocate outpatient services off station, which would improve the crowded conditions.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that floors and air ventilation outlets are cleaned routinely.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center purchased a special vacuum for vent cleaning, and one FTE is now dedicated to vent inspection and cleaning. Eleven FTE have been approved to serve on floor crews; they will be dedicated to intensive floor cleaning throughout the medical center. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that construction barriers remain sealed and that staff do not enter construction zones.

The VISN and Medical Center Directors concurred with our findings and recommendation. The construction area was secured, and training on Interim Life Safety Measures was provided. Ongoing rounds will be conducted to ensure that barriers are intact. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that clean equipment and

contaminated equipment are clearly identified and stored separately.

The VISN and Medical Center Directors concurred with our finding and recommendation. The unit with inadequate space has been reconfigured. Clean equipment and contaminated equipment will be stored separately. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that the safety hazards on the locked MH unit are corrected.

The VISN and Medical Center Directors concurred with our findings and recommendation. A new MH unit is due to open in November 2009. Until then, actions have been taken to provide for the safety of patients and staff. Staff are now making frequent rounds and providing additional observation. Also, the bathroom doors are now kept closed and locked. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that nurses comply with local policy regarding appropriate labeling of multi-dose medication vials.

The VISN and Medical Center Directors concurred with our findings and recommendation. A new process has been developed to improve medication vial labeling, and multi-dose vials have been eliminated when possible. The pharmacy is now tracking multi-dose vial expiration dates and removing expiring vials. The process has been piloted and will be put in place on all units. QM staff will monitor compliance. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the security of confidential patient information is maintained.

The VISN and Medical Center Directors concurred with our finding and recommendation. The Privacy Officer is monitoring and reporting privacy violations during weekly EOC rounds and is reinforcing compliance through awareness activities and education. The corrective actions

are acceptable, and we consider this recommendation closed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires that patient privacy is maintained.

The VISN and Medical Center Directors concurred with our findings and recommendation. A performance improvement team (PIT) has been chartered to address this issue, and the medical center has been awarded additional funding. Also, some ambulatory care functions will be relocated in December 2009, which will relieve overcrowding. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed a Suicide Prevention Coordinator (SPC) at the medical center and any very large CBOCs,[4] and we evaluated whether the SPC fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[5] documented safety plans that addressed suicidality, and documented collaboration between MH providers and the SPC.

We interviewed the medical center SPC and the Chief of the MH service line, and we reviewed pertinent policies and the facility self-assessment completed by the SPC. We found the suicide prevention program to be in compliance with VHA policy in all but one required program area. The medical center has a very large CBOC that did not have a full-time SPC. While we were onsite, medical center managers told us that they were recruiting to hire an SPC for that CBOC; therefore, we did not make a recommendation for this finding.

We reviewed the medical records of 11 patients determined to be at high risk for suicide. VHA regulations[6] require that medical records of patients at high risk for suicide have a

[4] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[5] A Category II PRF is an alert mechanism that is displayed prominently in medical records.
[6] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Category II PRF and a safety plan and show evidence of collaboration between the SPC and the patient's MH providers.

We found that required PRFs were present in 10 (91 percent) of the 11 records, and although only 7 (64 percent) of the 11 records contained documented evidence of collaboration between the SPC and MH providers, we found that the process has improved. The SPC's role was not full-time until December 2008. After that time, she began copying the patients' MH providers on her progress notes and attending discharge planning meetings. We also noted an increase in the frequency with which MH providers copied the SPC on their progress notes regarding high-risk patients. As collaboration was improving, we made no recommendations in this area. However, we identified the following condition that required management attention.

Safety Plans. We found that only 2 (18 percent) of the 11 records we reviewed contained evidence of a safety plan. Medical center practice was to have the patient's outpatient MH provider create the safety plan when the patient attended the first follow-up appointment after discharge. Safety plans should be developed earlier so that patients have them at the time of discharge.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans for patients deemed at high risk for suicide.

The VISN and Medical Center Directors concurred with our finding and recommendation. The SPC is now notified when high-risk patients are admitted to the medical center. A template has been put in place to track and report suicide risk behaviors, and the SPC is monitoring use of the template. Written safety plans are now being completed for patient discharges. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purposes of this review were to determine whether: (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 QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and

Federal and local regulations. We interviewed the medical center's senior management team and QM personnel. We reviewed policies and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 13 of the 15 program activities reviewed. However, we identified two areas that needed improvement.

Peer Review. The medical center did not fully comply with VHA policy,[7] which requires that results of VA patient M&M reviews[8] conducted at an affiliate university be shared with the PRC. While M&M reviews done at an affiliate facility can serve as an initial review, they must be referred to the PRC for final review and appropriate action.

Life Support Training. The medical center did not comply with VHA policy,[9] which requires that designated staff remain current in Advanced Cardiac Life Support (ACLS) and/or Basic Life Support (BLS) training. We found 83 percent compliance with ACLS training and 92 percent compliance with BLS training. Also, we found that the medical center did not have a system in place to monitor this training for timely completion, as required by local policy.

Recommendation 9 We recommended that the VISN Director ensure that the Medical Center Director requires that the affiliate university shares results of M&M reviews on VA patients with the PRC.

The VISN and Medical Center Directors concurred with our finding and recommendation. Information from M&M reviews conducted at the affiliate university will be forwarded to QM. The Surgery Service has developed a database of M&M reviews done at the affiliate and at the medical center. Results of the reviews will be followed up on as appropriate, and reports will be submitted to Risk Management. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

[7] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[8] M&M reviews are completed to discuss complications of care and lessons learned.
[9] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

Recommendation 10 We recommended that the VISN Director ensure that the Medical Center Director requires that all designated staff complete ACLS and/or BLS training and that a system is put in place to monitor compliance.

The VISN and Medical Center Directors concurred with our findings and recommendation. A database has been created to track ACLS and BLS training, and the Cardiopulmonary Resuscitation Committee will monitor compliance. The number of BLS classes offered has been increased, and new BLS and ACLS instructors are being recruited. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether the medical center had safe medication management practices that complied with medical center policy. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the acute inpatient medical and surgical units, the SICU, the SCI unit, and the CLC. We found adequate management of medications brought into the medical center by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. However, we identified the following area that needed improvement.

Documentation of PRN Effectiveness. The effectiveness of PRN pain medication was not consistently documented within 4 hours of administration, as required by local policy. We randomly selected 25 patients' medical records and reviewed 67 doses of PRN pain medication. We found that 25 (37 percent) doses did not have effectiveness documented within 4 hours of administration and that 5 (7 percent) doses had no documentation of effectiveness.

Recommendation 11 We recommended that the VISN Director ensure that the Medical Center Director requires that the effectiveness of PRN pain medication is documented in the EMR within the timeframe required by local policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. A PIT has been chartered to improve the process for documentation of PRN pain medication effectiveness. A reminder now automatically

prints on each unit at least every 3 hours, and charge nurses review the reminders. Pain resource nurses have been designated and trained to assist with the process. Data on timely documentation of PRN pain medication effectiveness is being collected, and monthly reports are being generated and shared with staff. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in the medical center's ED, including clinical services, consultations, inter-facility transfers, staffing, and staff competencies. We also assessed the ED's physical environment and ED equipment maintenance.

We interviewed program managers and transfer coordinators. Also, we reviewed competency files, credentialing and privileging (C&P) folders, and medical records of patients who were seen in the ED and subsequently transferred to other medical facilities, admitted to inpatient units within the medical center, or discharged home.

The ED is open 24 hours per day, 7 days per week, as required for ED designation. The ED environment and design are appropriate for the services provided, and patient privacy is maintained. Emergency services provided are within the facility's patient care capabilities, and the ED has state-of-the-art equipment, such as bariatric lifts and an electronic patient triage and tracking system.

We found that clinical services, consultations, staffing, and medical record admission and discharge documentation were appropriate. The ED nursing competency evaluation program was well developed, and competency assessments were completed annually, as required by local policy.

We reviewed the C&P folders of three ED physicians and found that the physicians who had been granted airway management and intubation privileges had documentation of out-of-operating room airway management training. We identified one area that needed management attention.

Inter-Facility Transfers. ED staff did not fully document inter-facility transfer information, as required by VHA policy.[10] We reviewed the medical records of three patients who were

[10] VHA Directive 2007-015, *Inter-facility Transfer Policy*, May 7, 2007.

transferred from the ED to other facilities. All of the elements of VA transfer forms "10-2649A" and "10-2649B" were not included in the locally developed form used for patient transfers. Additionally, the form was only used for one of the three patients.

Recommendation 12 We recommended that the VISN Director ensure that the Medical Center Director requires that transfer documentation is completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with our findings and recommendation. The medical center's transfer form has been revised and is now compliant with VHA policy. The revised form is being used for all inter-facility transfers, and staff have been educated on the process for scanning the forms into the EMR. The Hospital Administration Service is tracking compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Contract/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in the medical center through contracts or temporary agencies met the same entry requirements as RNs hired as part of the medical center's staff. We reviewed documents for several required components, including licensure, training, and competencies. Also, we reviewed six files of contract/agency personnel who worked at the medical center within the past year. Although the medical center very recently ceased using contract/agency staff, contract/agency staff may be used in the future. We identified three areas that needed improvement.

Training. VA and VHA require several training courses for staff as well as contract/agency RNs.[11] We did not find evidence that all mandatory training was completed. Documentation of the required VHA information security and privacy training for two of the six contract/agency RNs was not present. However, those two RNs had access to VHA computer systems and confidential patient information.

Clinical Competence. According to local policy, the agency sponsoring the contract/agency RN is expected to present evidence of current clinical competence, and the medical center is to complete VA and unit-specific orientation and

[11] VHA Directive 2007-026, *Mandatory and Required Training for VHA Employees*, September 17, 2007.

competency requirements. We found complete competency documentation for only three of the six contract/agency RNs.

Background Investigations. U.S. Government agencies are required to complete background investigations for employees in sensitive positions.[12] We found no documentation of completed background investigations for any of the six contract/agency RNs.

Recommendation 13 We recommended that the VISN Director ensure that the Medical Center Director requires nursing managers to validate that contract/agency RNs have completed mandatory training and presented evidence of clinical competence and have documentation of completed background investigations prior to providing patient care.

The VISN and Medical Center Directors concurred with our findings and recommendation. The local policy addressing the use of contract/agency RNs was revised to include the missing elements. All agency staff are now required to complete annual competency requirements, and records will be maintained in the Nursing Recruitment and Retention Office. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (unit-to-unit) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 18 inpatients who had consultations ordered and performed internally. In general, we found that all inpatients received consultative services within acceptable timeframes. We reviewed the medical records of 15 patients who were transferred between units and found appropriate nursing and physician notes from sending to receiving units. We also reviewed the medical records of 15 discharged patients and found that

[12] Executive Order 10450, *Security Requirements for Government Employment*, April 27, 1953, Sec. 3.

13 (87 percent) received appropriate written discharge instructions. We made no recommendations.

Patient Satisfaction

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 Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients.

The purpose of this review was to assess the extent that the medical center uses SHEP data to improve patient care, treatment, and services. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

The graphs on the next page show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure (PM) results for inpatients. Figure 2 shows the medical center's SHEP PM results for outpatients.

The medical center's overall inpatient SHEP scores for the 1st quarter of FY 2007 through the 4th quarter of FY 2008 met or exceeded the target in 7 of the 8 quarters. Outpatient scores for that same timeframe met or exceeded the target in all 8 quarters. Courtesy scores were consistently high.

The medical center has an active Customer Service Council (CSC), which reports to the Senior Leadership Council. In FY 2008, the CSC completed a charter, finalized their strategic goals, and expanded their membership and participation. A notable accomplishment was the distribution to all patients of Healthwise Handbooks, wall calendars with medical information, and pocket calendars with important facility phone numbers. Also, the CSC implemented the "We're Listening to You" poster program and continued the highly successful Gold Star program, which rewards staff for exemplary customer service. We made no recommendations.

Figure 1:

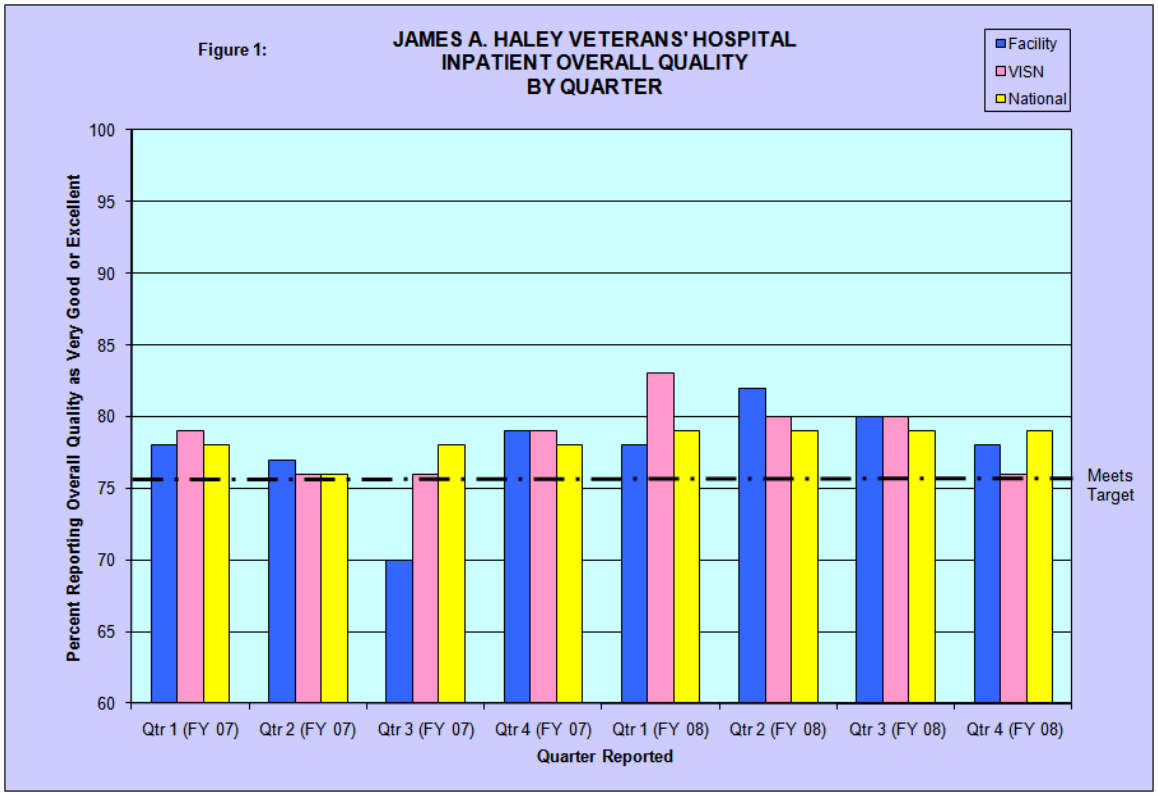
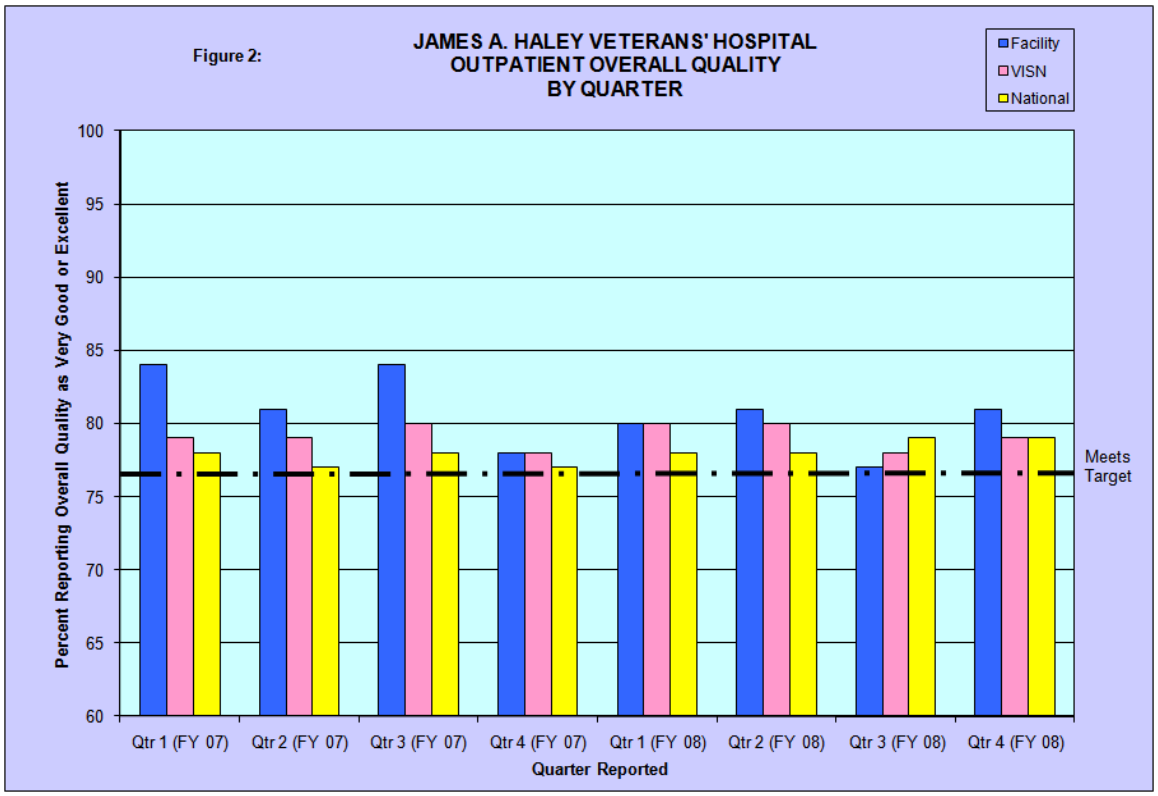


Figure 2:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 5, 2009

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

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

To: Associate Director, St. Petersburg Regional Office of Healthcare Inspections (54SP)

Director, Management Review Service (10B5)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the James A. Haley VA Hospital.

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

(original signed by:)

Nevin M. Weaver, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2009

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

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

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

1. On behalf of the James A. Haley Veterans' Hospital, I want to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted on March 2 through March 6, 2009.

2. The results of their review validate the efforts of the James A. Haley Veteran's Hospital's employees to provide high quality health care to our nation's veterans and active duty service members.

3. I concur with the findings and recommendations of this Office of Inspector General report. Tampa has been actively working to improve or enhance several of these areas and welcome the external perspective provided by this report.

4. Included herein is an outline of improvement activities already taken, in progress, or planned in response to these findings.

(original signed by:)

Stephen M. Lucas

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 Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that floors and air ventilation outlets are cleaned routinely.

Concur

Vent Cleaning: A portable, lightweight hepa-filter vacuum for vent cleaning was purchased and one FTEE is now dedicated to recurring inspection and cleaning of all vents throughout the facility. The dedicated FTEE utilizes a handheld computer for documenting and tracking vents inspected, vents cleaned, and vents needing facility management attention (internal cleaning). As of June 4, 2009, over 80 percent of vents have been inspected and cleaned. Monthly reports for vent cleaning status are generated and, as of May 2009, are reviewed by the Hospital Occupational Health and Safety Committee.

Status: Complete. Recommend closure.

Floor Cleaning: 11 FTEE have been approved for floor crews to work in teams of three to strip, clean, and wax floors throughout the hospital. Six of the 11 FTEE are in place and have started intensive floor cleaning. These FTEE do not have collateral duties and rotate to evenings and nights so that patient and non-patient care areas can be accommodated.

Status: In process Targeted Completion Date: August 1, 2009

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that construction barriers remain sealed and that staff do not enter construction zones.

Concur

Investigation determined that EEG staff disrupted the barrier during the visit. Construction area was secured and staff in that specific area was instructed on the importance of maintaining a secure barrier. Training by the Safety Office on ILSM for construction areas includes the importance of maintaining a secure barrier and whom to call if a problem is

discovered. Ongoing rounds occur to ensure that barriers are intact and are not disrupted by staff or contractors.

Status: Complete. Recommend closure.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that clean equipment and contaminated equipment are clearly identified and stored separately.

Concur

The unit was reconfigured and a different room was designated for soiled scopes completely separating clean and contaminated equipment. Remodeling is now occurring.

Status: In process Targeted Completion Date: August 1, 2009

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that the safety hazards on the locked MH unit are corrected.

Concur

Several measures have been implemented to provide for safety on the locked MH unit until the move to the new unit takes place. The TV cord was shortened and wall mounted flat screen televisions have been ordered. New heavier furniture made by Blockhouse has been ordered for the new unit. An interim plan of action for the existing day room furniture includes frequent staff rounds (at least every 15 minutes depending on patient acuity). The day room is directly across from the nursing station so additional observation is in place. The female bathroom is kept closed, locked and is under staff observation. Possession of the new unit from the contractor is anticipated for August 31, 2009, and patient relocation is expected to occur by November 1, 2009.

Status: In process Targeted Completion Date: November 1, 2009

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that nurses comply with local policy regarding appropriate labeling of multi-dose medication vials.

Concur

A new process has been developed to improve labeling of medication vials. Multi-dose vials have been eliminated whenever possible. Pharmacy now codes the expiration date in the Pyxis system, and Pharmacy technicians go to the ward to remove any expiring multi-dose vials. Pharmacy places a yellow label on each multi-dose vial when it is

sent to a unit. The label includes the date the vial was opened and the expiration date (28 days later), following local policy. Certain multi-dose vaccine vials are kept in the Pharmacy, and a labeled single-dose syringe is sent to the unit when the vaccine is ordered. Staff education and a pilot of the new process is complete. As of June 1, 2009, education began on this new process for all nursing units. QM staff continues to monitor patient care areas for compliance with local policy.

Status: In process Targeted Completion Date: July 1, 2009

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of confidential patient information is maintained.

Concur

The Privacy Officer/Information Security Officer continues to monitor and report results of violations during weekly EOC rounds and reinforces compliance through screen savers, awareness activities, mandatory annual training, and new employee orientation. Since March 18, 2009, the EOC rounds have visited 45 areas and provided immediate education and follow up with staff where any issues with confidentiality were identified.

Status: Complete. Recommend closure.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that patient privacy is maintained.

Concur

A PIT was chartered to review all patient functions on the 3rd floor with attention to flow, scheduling and patient privacy. Three Oncology providers will be moving off floor in June 2009. The facility was awarded a $1,500,000 Systems Improvement Grant to work on flow, privacy and scheduling issues on the third floor where all of these areas reside. In December 2009, when ambulatory care functions relocate off station, it is expected that this decompression will help the severe overcrowding in that area.

Status: In process Targeted Completion Date: December 1, 2009

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA regulations regarding documentation of safety plans for patients deemed at high risk for suicide.

Concur

The SPC is being notified of all high-risk patients upon admission to the hospital. A template was developed and activated on March 5, 2009. This note allows tracking and reporting of suicide behavior (risk). The SPC has been monitoring the use of the template since May 6, and a written safety plan has been completed for all relevant patient discharges. Eighteen suicide behavior reports were completed in May 2009, and 12 have been generated to date for June 2009.

Status: Completed. Recommend closure.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that the affiliate university shares results of M&M reviews on VA patients with the PRC.

Concur

Data, findings, recommendations, and actions from the M&M reviews conducted at the affiliate university will be forwarded to the QM Service for performance improvement. Surgery Service has developed a data base of morbidity and mortality reviews done at the affiliate and at the VA. Those reviews that are a level one will be incorporated into the Protected Peer Review process. M&M reviews with systems issues or findings of Level 2 or 3 will be presented at the peer review committee for final determination of level and tracking of systems issues. The first report is due to Risk Management by June 30, 2009.

Status: In process Targeted Completion Date: July 30, 2009

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that all designated staff complete ACLS and/or BLS training and that a system is put in place to monitor compliance.

Concur

A data base has been created to track ACLS and BLS training. Human Resources (HR) enters new employees into the database and the service chief indicates which employees require BLS/ACLS. The CPR coordinator and the Designated Learning Officer will ensure the tracking log is maintained and reports of compliance are sent to the CPR Committee for review and follow up. BLS classes were increased to 50 per year with each class accommodating up to 50 employees. Recruitment efforts for volunteers for BLS and ACLS instructors are in progress in order to expand the capacity to train more staff. A new scheduling process to decrease class cancellations has been developed and is being piloted.

Status: In process Targeted Completion Date: August 1, 2009

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that the effectiveness of PRN pain medication is documented in the EMR within the timeframe required by local policy.

Concur

A PIT has been chartered to improve the process for documentation of PRN effectiveness. A pilot was conducted on two patient care units. A hard copy reminder of all patients' administered PRN medications automatically prints at least every 3 hours, and is reviewed by the charge nurse for follow-up documentation as appropriate. Each unit/ward has a Pain Resource Nurse to help with this process and other patient care issues related to pain. Fifty Pain Resource Nurses were trained on March 28–30, 2009, and 25 more were trained on June 1–2, 2009. Each clinical area is collecting data on timely PRN Effectiveness documentation through use of a database that was specifically created to allow for monitoring of PRN effectiveness documentation. Process improvements have been made and compliance is improving but not yet at desired level of 90 percent or greater for all areas. Monthly reports are generated and shared with staff and PI team members.

Status: In process Targeted Completion Date: August 1, 2009.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that transfer documentation is completed in accordance with VHA policy.

Concur

VA form 10-2649A and 10-2649B (Inter-Facility Transfer forms) have been revised to be compliant with VHA policy. This form is currently being used for all transfers from the facility and is required prior to transfer. On May 29, 2009, Medical Records staff was educated on the process for scanning these documents into the Medical Record. A Hospital Administration Service employee now receives a copy of the transfer forms and has tracked compliance since June 1, 2009.

Status: Completed. Recommend closure.

Recommendation 13: We recommended that the VISN Director ensure that the Medical Center Director requires nursing managers to validate that contract/agency RNs have completed mandatory training and presented evidence of clinical competence and have documentation of completed background investigations prior to providing patient care.

Concur

The local Nursing Service Policy for use of contract/agency RNs was revised to include the missing elements per OIG recommendations. All agency staff is now required to complete annual competency requirements, and records are maintained in the Nursing Recruitment and Retention Office. The Nurse Managers receive copies of the employee's initial orientation checklist competencies. Training and complete performance evaluations are done annually and/or at the end of agency staff employment with the VA. Evaluations are maintained in the Office of Nursing Recruitment and Retention. This office also ensures that a copy of documentation verification of completed background investigations is in the employee's competency folder prior to providing patient care. Compliance with and effectiveness of this revised process will be evaluated by July 1, 2009.

Status: In process Targeted Completion Date: July 1, 2009

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