Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-02084-01

Combined Assessment Program Review of the Orlando VA Medical Center Orlando, Florida

October 17, 2011

Washington, DC 20420

Why We Did This Review

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

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

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

Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
DBC	Disruptive Behavior Committee
EN	enteral nutrition
EOC	environment of care
facility	Orlando VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MH	mental health
MSDS	Material Safety Data Sheet
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Orlando VA Medical Center, Orlando, FL

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of August 8, 2011.

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

- Enteral Nutrition Safety
- Quality Management
- Registered Nurse Competencies

The facility's reported accomplishments were the military honors ceremony upon the death of a veteran in the hospice unit and the development and implementation of a system that has reduced the response time for team assistance in the management of a suicide call.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Complete annual N95 respirator fit testing for designated employees, and monitor compliance. Document daily inspections of Mental Health Residential Rehabilitation Treatment Program residents' rooms for unsecured medications, and monitor compliance. Ensure that Material Safety Data Sheet inventory lists and hazardous material information sheets are current and complete.

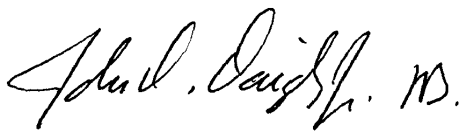
Continuity of Care: Ensure that providers follow up with patients discharged from community hospitals. Require patients referred to non-VA providers to receive care within 30 days.

Management of Workplace Violence: Ensure all incidents of threatening or disruptive behavior are referred to the Disruptive Behavior Committee.

Physician Credentialing and Privileging: Report results of completed Focused Professional Practice Evaluations for all newly hired physicians to the Professional Standards Board.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
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 administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

- Continuity of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through August 8, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we also presented crime awareness briefings for 306 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.

Reported Accomplishments

Hospice Military Honors Ceremony

Military honors ceremonies are held upon the death of a veteran in the hospice unit. The veteran's picture and branch of service are placed on the Memorial Wall, and the body is draped with the American flag. A public announcement is made honoring the service of the veteran, and there is a procession through the community living center with veterans, staff, and family as honorary pallbearers. All attending veterans salute at the Memorial Wall as the national anthem is played. The ceremony includes readings, the playing of Taps, and a final procession.

Personalized sympathy cards are sent to the family from the facility's Director, the chaplain, and executive and community living center staff. The chaplain follows up with the family a few days after the ceremony to offer further assistance. The veteran's name, dates of birth and death, and branch of service are engraved on a gold leaf on the Memorial Tree, and the family is invited to view the tree. This dignified and respectful celebration of life has been very well received by the families of those veterans so honored.

Suicide Alert Veterans Emergency System

Telecare staff provide telephone advice to patients who call in. The Telecare Suicide Redesign work group developed a plan to improve the response time for managing a call from a suicidal patient and reduce the time for rescue action.

Working with information technology staff, the group developed a desktop icon that is placed on telecare computers. Staff click on this icon while they are on the phone with a patient in crisis, and an instant message with applicable details is sent out. This allows one staff member to remain on the phone while another staff member goes for help.

Results show that the elapsed time from a suicidal patient's call to team assistance in the management of the call has decreased from 5 minutes to 10 seconds, and rescue

assistance now arrives at the patient's home within 25 minutes. Implementation of the Suicide Alert Veterans Emergency System was a cost effective way to improve patient safety.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the Domiciliary Care for Homeless Veterans and Substance Abuse RRTPs complied with selected MH RRTP requirements.

We inspected the ambulatory surgery and post-anesthesia areas; three community living center units; and the MH, wound care, infusion, dental, and women's clinics. We also inspected the Domiciliary Care for Homeless Veterans and Substance Abuse RRTP units. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires facilities using N95 respirators to fit test designated employees annually. We reviewed 17 employee records and determined that 7 designated employees did not have the required annual fit testing.

MH RRTP Daily Medication Inspections. VHA requires that resident rooms be inspected daily for unsecured medications.[1] We reviewed documentation of daily resident room inspections for unsecured medications for 4 randomly selected weeks from the months of February, March, and April 2011. We found that unit staff were not consistently documenting that inspections were being conducted.

Environmental Safety. The Occupational Safety and Health Administration and The Joint Commission require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used in clinical areas. We reviewed 11 MSDS inventory lists and hazardous material information sheets, and found that 5 were not current or complete.

[1] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, May 26, 2009.

Recommendations

1. We recommended that processes be strengthened to ensure that annual N95 respirator fit testing is completed for designated employees and that compliance is monitored.

2. We recommended that processes be strengthened to ensure that daily inspections of resident rooms for unsecured medications are documented and that compliance is monitored.

3. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information sheets are current and complete.

Continuity of Care

The purpose of this review was to evaluate whether VA patients hospitalized in non-VA facilities had appropriate post-discharge follow-up by VA providers and whether patients referred to non-VA providers for outpatient care were seen within the required timeframe.

Post-Discharge Follow-Up. The Chief of Primary Care told us that she expected primary care providers to follow up with patients discharged from community hospitals. We reviewed the medical records of 20 patients who had been hospitalized in the community. We found that 3 of the 20 patients did not receive post-hospitalization follow-up with their designated primary care or MH provider.

Outpatient Care Referrals. VHA requires that patients referred for outpatient care be seen within 30 days.[2] We reviewed the medical records of 17 patients who were referred to non-VA providers for outpatient care in the community. We found that 5 of the 17 patients did not receive care within 30 days.

Recommendations

4. We recommended that processes be strengthened to ensure that providers follow up with patients discharged from community hospitals.

5. We recommended that processes be strengthened to ensure that patients referred to non-VA providers receive care within 30 days.

Management of Workplace Violence

The purpose of this review was to determine whether the facility issued and complied with comprehensive policy regarding violent incidents and provided required training.

[2] VHA Directive 2006-041, *Veterans Health Care Service Standards,* June 27, 2006.

We reviewed the facility's policy and training plan. We selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. We identified the following areas that needed improvement.

DBC Referrals. Facility policy requires that the DBC collect and analyze all incidents of threatening and disruptive behavior. We reviewed three cases of assaults by patients and found that two cases were not referred to the DBC.

Recommendation

6. We recommended that processes be strengthened to ensure that all incidents of threatening or disruptive behavior are referred to the DBC.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

FPPE. Facility process requires that an FPPE be completed for all newly hired physicians and that results be reported to the Professional Standards Board. The five newly hired physicians whose profiles we reviewed did not have results of completed FPPEs reported to the Professional Standards Board.

Recommendation

7. We recommended that results of completed FPPEs for all newly hired physicians be reported to the Professional Standards Board.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. The QM program was generally compliant with requirements, and senior managers supported the program. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policies and processes, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that actions were taken when deficiencies were identified. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 9–13, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[3]		
Type of Organization	Outpatient medical center	
Complexity Level	1c	
VISN	8	
Community Based Outpatient Clinics	Clermont, FL Daytona Beach, FL Leesburg, FL Kissimmee, FL Orange City, FL Viera, FL	
Veteran Population in Catchment Area	294,257	
Type and Number of Total Operating Beds: • **Psychosocial RRTP**	60	
• **Community Living Center/Nursing Home Care Unit**	118	
• **Other**	None	
Medical School Affiliation(s)	University of Central Florida College of Medicine Florida State University College of Medicine	
• **Number of Residents**	4.5	
	FY 2011 (through July 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$466	$358
• **Medical Care Expenditures**	$297	$358
Total Medical Care Full-Time Employee Equivalents	1,952	1,822
Workload:		
• **Number of Station Level Unique Patients**	83,928	88,661
• **Inpatient Days of Care:**		
o **Acute Care**	NA	NA
o **Community Living Center/Nursing Home Care Unit**	25,421	38,294
Hospital Discharges	NA	NA
Total Average Daily Census (including all bed types)	160	163
Cumulative Occupancy Rate (in percent)	90	91
Outpatient Visits	737,552	1,048,757

[3] All data provided by facility management.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

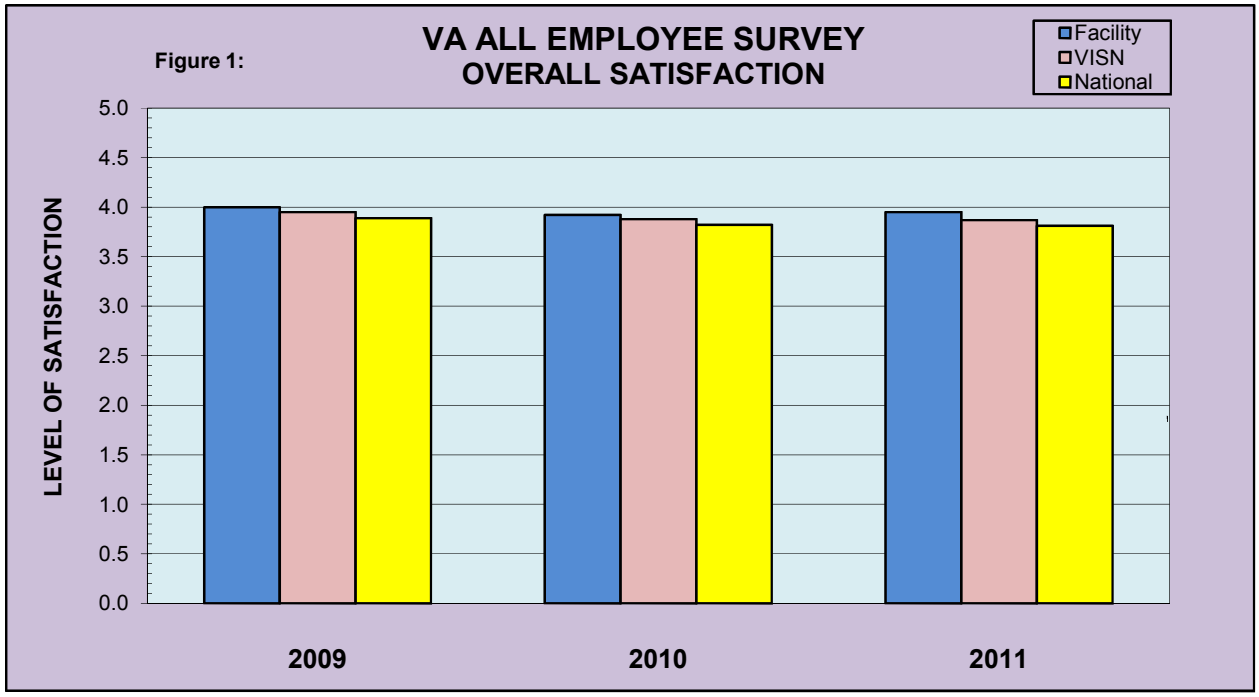
Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	45.8	49.7	*	54.8	49.8
VISN	64.7	56.5	56.4	68.1	56.6	58.2
VHA	64.1	54.8	54.4	63.9	55.9	55.3

* Facility does not provide inpatient care

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 22, 2011

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

Subject: **CAP Review of the Orlando VA Medical Center, Orlando, FL**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the Orlando VA Medical Center, Orlando, Florida.

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

Nevin M. Weaver

Nevin M. Weaver, FACHE

Facility Director Comments

Department of Veterans Affairs& **Memorandum**

Date:& September 21, 2011

From:& Director, Orlando VA Medical Center (675/00)

Subject:& **CAP Review of the Orlando VA Medical Center, Orlando, FL**

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

1. We thank you for allowing us the opportunity to review and respond to the subject report.

2. We concur with the conclusions and recommendations presented by the Office of the Inspector General. We present you with the plans of action designed to correct those areas for which recommendations were provided.

(original signed by:)
Timothy W. Liezert

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 processes be strengthened to ensure that annual N95 respirator fit testing is completed for designated employees and that compliance is monitored.

Concur

9/30/11

The OVAMC Respiratory Protection Program contains the plan for employees requiring respiratory protection. The list of employees, based on position, activity and other risk of exposure, was approved by the Safety Manager and the Infection Control Coordinator. Currently, OVAMC has 204 employees in the Respiratory Protection Program to include employees from CLC, specialty clinics, and the pulmonary, bronchoscopy, and endoscopy suites who received annual N95 fit testing as required. These employees are medically cleared prior to initial fit testing and are fit tested annually. To ensure reliability of the process is maintained, all fit testing records, actual fit testing and evidence of satisfactory medical clearance documentation from Occupational Health will be kept in the Safety Office. Fit testing is performed on an established basis each month. Ongoing compliance will be monitored in both the EOC Committee and in the Infection Control Program annual review, noting compliance with performing initial/ annual respirator fit testing. Results of fit testing will be tracked in the database and posted on a SharePoint.

Recommendation 2. We recommended that processes be strengthened to ensure that daily inspections of resident rooms for unsecured medications are documented and that compliance is monitored.

Concur

Completed

The daily Domiciliary residential room inspection log was revised to clearly separate and identify the components. The daily inspection log distinguishes (1) the daily room inspection for unsecure medications conducted each evening and (2) the resident accountability checks that are conducted each a.m. (6:00 a.m.) and p.m. (11:30 p.m.). The Domiciliary Tech. ensures that the log is completed daily for each of the above items and quality process reviews are conducted wherein the daily log is reviewed during morning report. Weekend logs are reviewed during the Monday morning report. The Program Director ensures compliance and monitoring with the daily inspections.

Recommendation 3. We recommended that processes be strengthened to ensure that MSDS inventory lists and hazardous material information sheets are current and complete.

Concur

10-31-11

Three MSDS binders (CLC) out of six were corrected the same day of the finding. The remaining MSDS binders were corrected within the same week. To ensure immediate compliance to the process, all services were notified to ensure MSDS binders have both the up-to-date inventory sheets and corresponding MSDSs. Each year an annual update of chemical inventory with accompanying MSDS forms is performed by the service and submitted to the Safety Office. Ongoing compliance of MSDS books for current documentation will be conducted during scheduled EOC rounds.

Recommendation 4. We recommended that processes be strengthened to ensure that providers follow up with patients discharged from community hospitals.

Concur

Completed

Integrated Health Service/Care Management has provided and will continue to expand on communicating the potential discharges of patients from community hospitals to all of the OVAMC Chief Medical Officers and the Chief of Primary Care (PC) via a list with patients and anticipated or actual discharge date. The report is also designed to highlight any patient that has a pending appointment over 3 days to ensure timeliness of post discharge appointment. The process to ensure follow up includes the assigned PC team/service coordinating the patient's post discharge appointment, using this list, with either a face-to-face or telephone contact visit with the patient and assigned Primary Care Provider or Team Liaison within 2-7 days post discharge. A process review will begin Quarter 1 FY 12 with a review of Quarter 4 FY 11 data to monitor performance. This ongoing monitoring of the process and review/audit of charts will ensure that coordination has occurred from discharge to post-discharge appointment/visit.

Recommendation 5. We recommended that processes be strengthened to ensure that patients referred to non-VA providers receive care within 30 days.

Concur

Completed

IHS/Non-VA Purchased Care will continue to monitor and trend consult referrals to Fee Basis from the time of receipt of service until service completion. Monitoring of this data is maintained in a tracking tool. In order to ensure compliance, concurrent review of the tracking tool is performed. The consults are tracked by use of the clinical tracking tool for the high risk services. The data are trended monthly with accompanying graphs.

Consult completion time is also tracked and trended. A process review will begin Quarter 1 FY 12 with a review of Quarter 4 FY 11 data to monitor performance. This ongoing monitoring of the process and review/audit of charts will ensure that coordination of referrals to non-VA providers for care within 30 day time frame is met and consults are closed out.

Recommendation 6. We recommended that processes be strengthened to ensure that all incidents of threatening or disruptive behavior are referred to the DBC.

Concur

Completed

The Disruptive Behavior Committee is now reviewing all patient/patient-patient/patient-employee assaults as they are reported. The process to ensure all reports are received was strengthened by (a) re-education to all Committee members; (b) review of reporting process with Police; and (c) reinforcement of reporting in the CLC with long term patients that may exhibit disruptive behaviors. Reports have increased and now include additional reports from the CLC and Police. OVAMC police are reporting all relevant assaults to the DBC on an ongoing basis. This information is reviewed and addressed by the Committee as a recurring agenda item. Four new patient record flags have been assigned as a result of last month's reports and consideration by the DBC.

Recommendation 7. We recommended that results of completed FPPEs for all newly hired physicians be reported to the Professional Standards Board.

Concur

Completed

FPPE due dates for all newly hired physicians are recorded in the Professional Standards Board (PSB) minutes. The names of the providers and the FPPE due dates will remain on the PSB agenda for monitoring compliance until completed results are submitted to the credentialing office in accordance with policy. Bi-weekly reminders are sent to the Service Chiefs and Chief of Staff for the respective provider(s) until submission of the completed FPPE.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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