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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.

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CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EOC	environment of care
facility	West Palm Beach VA Medical Center
FY	fiscal year
HF	heart failure
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
MSDS	Material Safety Data Sheet
OIG	Office of Inspector General
OMHS	Office of Mental Health Services
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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5HYLHZ 3XUSRVH 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 December 5, 2011.

5HYLHZ 5HVXOWV The review covered eight activities. We made no recommendations in the following activity:

- Coordination of Care

The facility's reported accomplishments were developing methods for medication safety for women of childbearing age and creating a variance cost reporting spreadsheet to predict additional services required to meet patient care needs.

5HFRPPHQGDWLRQV We made recommendations in the following seven activities:

Environment of Care: Ensure that the Nursing Service Material Safety Data Sheet inventory list and hazardous material information binder is current and that staff are trained on accessing the electronic program. Require that electronic elopement prevention systems are checked every 24 hours; that medications, chemicals, and solutions are secured; and that clean and dirty supplies are properly stored.

Polytrauma: Appropriately assign Case Managers to outpatients. Ensure treatment plans contain all required elements. Ensure that required services are available to outpatients and that minimum staffing levels are maintained.

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe.

Medication Management: Screen patients for tetanus vaccinations upon admission and at clinic visits. Document all required pneumococcal and tetanus vaccination administration elements.

Quality Management: Ensure the Peer Review Committee is notified in writing when corrective actions are completed.

Moderate Sedation: Ensure staff maintain current training.

Psychosocial Rehabilitation and Recovery Centers: Complete the steps to receive designation by the Office of Mental Health Services.

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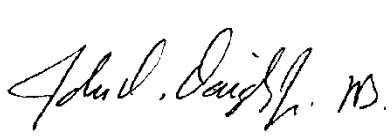
The Veterans Integrated Service Network and Acting Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.



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

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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.

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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 eight activities:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through December 5, 2011, 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 facility (*Combined Assessment Program Review of the West Palm Beach VA Medical Center, West Palm Beach, Florida,* Report No. 10-01192-63, January 18, 2011). (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 133 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 360 responded. Survey results were shared with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

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The Women's Health Program manager worked closely with the pharmacy and clinical informatics departments to develop a method to identify women in their childbearing years who may be on medications that could harm a fetus. A clinical reminder that identifies chronic medical diseases and medications that can cause birth defects has been put in place for women who have not yet conceived. Additionally, Pharmacy Service placed warnings in the comments section of certain medication order screens to alert the ordering provider that the medication can cause birth defects. With this information, the provider can counsel patients and ensure that medications are reviewed, risk/benefits are discussed, contraception is advised, and alternative plans are implemented if needed.

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In addition to the National Utilization Management Integration database system used to track same day and continued stay inpatient variances (patients whose hospital length of stay or care needs exceed expectations), facility utilization management staff created a spreadsheet to track cost values for level of care variances. With this information, the facility can identify an actual dollar value associated with variances and plan for cost effective expenditures, such as construction or expansion of services, to meet patient care needs.

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The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the medical and surgical intensive care, surgery/oncology, locked inpatient MH, dialysis, and hospice units and two CLC units. We also inspected the emergency department, operating room, outpatient cancer center, women's clinic, and dental clinic. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

1RQFRPSOLDQW	$UHDV 5HYLHZHG IRU(2&
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
X	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
X	The facility complied with any additional elements required by local policy.
	$UHDV 5HYLHZHG IRU0 + 5HVLGHQWLDO5HKDELOLWDWLRQ7UHDWPHQW3URJUDP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Environmental Safety. The Occupational Safety and Health Administration and The JC require that facilities maintain current MSDS inventory lists and hazardous material information for chemicals used within their facility. Local policy requires that each service maintain one current service-specific hard copy inventory list and hazardous material information binder in addition to the facility-wide electronic MSDS program. Local policy also requires initial training on MSDS chemicals for new employees and

annual training thereafter. This training includes where the service MSDS binder and inventory list is located and how to access chemical inventory and MSDS information electronically. We found that the Nursing Service MSDS inventory list and hazardous material information binder was not current. Additionally, we interviewed eight nurses and found that seven of them were not knowledgeable about how to access the electronic MSDS program.

The JC and the Occupational Safety and Health Administration require that chemicals and solutions be appropriately stored to minimize or eliminate safety and security risks in the physical environment. On the dialysis unit, we found several unsecured chemicals and solutions outside the nurses' station and inside treatment rooms.

VHA requires that functionality checks be performed at least every 24 hours on electronic elopement prevention systems in CLCs.[1] We reviewed randomly selected alarm testing documentation for the months of August and September 2011 for two CLC units and found that one CLC unit only performed alarm testing weekly.

Infection Prevention. The JC requires the appropriate storage of clean and dirty supplies and the appropriate disposal of dirty supplies to minimize or eliminate identified safety and security risks in the physical environment and to prevent the spread of infection. On the locked inpatient MH unit, we found clean and dirty clothing stored together inside a laundry room, three bags of clean linens on the floor inside the linen room, and an open package of gauze on top of a computer in the treatment room. We also found dirty linens and dirty supplies on top of a table and a treatment cart in the dialysis unit.

Medication Security. The JC requires that medications be secured from unauthorized persons. In a dialysis treatment room, we found several unsecured and unlabeled medications on top of a treatment cart.

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We recommended that processes be strengthened to ensure that the Nursing Service MSDS inventory list and hazardous material information binder is current and complete and that staff are trained on how to access the electronic MSDS program.

We recommended that processes be strengthened to ensure that testing is performed on CLC electronic elopement prevention systems every 24 hours.

We recommended that processes be strengthened to ensure that medications, chemicals, and solutions on the dialysis unit are properly secured and that clean and dirty supplies on the locked inpatient MH unit and the dialysis unit are properly stored and that dirty supplies are properly discarded.

[1] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 3, 2010.

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The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, 10 medical records of outpatients being followed by the polytrauma team, and staff training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

1RQFRP SOLDQW	\$UHDV5HYLHZHG
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
X	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that polytrauma outpatients who need interdisciplinary care have a Case Manager assigned and a specific interdisciplinary treatment plan developed.[2] The plan developed by the interdisciplinary team must address specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. Two of the six polytrauma outpatients who had interdisciplinary needs did not have a Case Manager assigned. In addition, none of the six patients had treatment plans completed.

Available Services and Staffing. VHA requires that specific services be available for polytrauma patients and that minimum staffing levels be maintained.[3] The facility did

[2] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[3] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

not offer patient/family education in topics related to polytrauma. In addition, the facility did not meet the minimum staffing requirement for nursing, physical therapy, psychology, or social work.

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We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

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The purpose of this review was to follow up on the report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

1RQFRP SOLDQW	$UHDV5HYLHZHG
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[4] Four of the seven patients who received diagnostic testing did not receive that testing within the required timeframe.

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We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

[4] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).

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The purpose of this review was to determine whether the facility had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal, tetanus, and shingles vaccines to 10 CLC residents and screening and administration of tetanus and shingles vaccines to 10 primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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X	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
X	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Seven of the 20 medical records lacked documentation of tetanus vaccination screening.

Vaccination Documentation. Federal law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used. Clinicians did not document all required elements for pneumococcal vaccines in three of the CLC residents' medical records and for tetanus vaccines in 3 of the 20 total medical records.

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We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

We recommended that processes be strengthened to ensure that clinicians document all required pneumococcal and tetanus vaccination administration elements and that compliance be monitored.

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The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within their QM program.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

1RQFRP SOLDQW	$UHDV5HYLHZHG
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

1 RQFRP SOLDQV	$UHDV 5 HYLHZ HG
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Peer Review. VHA requires that the Peer Review Committee receive written notification upon completion of corrective actions related to peer review findings.[5] For the period March 2011–October 2011, we identified 10 corrective actions that had been completed; however, there was no evidence that the Peer Review Committee received written notification.

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We recommended that processes be strengthened to ensure that the Peer Review Committee is notified in writing when corrective actions are completed.

[5] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

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The purpose of this review was to determine whether the facility developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 12 medical records, and training/competency records, and we interviewed key individuals. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

1RQFRP SOLDQW	\$UHDV5HYLHZHG
X	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Staff Training. Local policy requires that non-physician clinical staff in each moderate sedation area complete appropriate training biannually. We reviewed the training records of 40 non-physician clinical staff and found that moderate sedation training requirements for 21 (53 percent) staff were not current.

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We recommended that processes be strengthened to ensure that all clinicians caring for patients receiving moderate sedation maintain current training.

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The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an OMHS approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

1RQFRPSOLDQW	$UHDV5HYLHZHG
X	A PRRC was implemented and was considered fully designated by the OMHS, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

PRRC Modification or Exception. VHA directed that facilities fully implement PRRCs and that the PRRCs be fully designated by September 30, 2009, or that facilities have an approved modification or exception.[6] The facility's program had not been approved by the OMHS as a fully designated PRRC. Without this designation, facilities cannot use the PRRC stop codes to capture workload and cannot seek accreditation. In addition, the facility had not requested an appropriate modification or exception to extend the deadline. While we were onsite, the facility completed their application package and was preparing to send it to the OMHS for approval.

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We recommended that the facility complete the steps to receive PRRC designation by the OMHS.

[6] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

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The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 25 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

1RQFRPSOLDQW	$UHDV5HYLHZHG
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

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The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 20–26 for full text of the Directors' comments.) We consider Recommendations 9 and 11 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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[7] All data provided by facility management.

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1. Strengthen the security of the "mobile" MRI unit.	A panic button was installed beneath the desk in the "mobile" unit; the door to the unit is locked at all times.	N
2. Label equipment used in MRI areas as safe or unsafe, and properly clean and maintain the MRI compatible ventilator to ensure that unsafe supplies are not left with the equipment.	All equipment has been labeled with color coded "MRI Safe" and "MRI Unsafe" stickers. Anesthesia Service created a Memorandum of Understanding between imaging and anesthesia to ensure that the anesthesia cart is kept in the MRI suite and is cleaned and maintained after use.	N
3. Place a physical barrier in the Radiology Service MRI suite to prevent unauthorized or accidental entry to Zones III and IV.	A keypad lock was installed on the entrance to the MRI suite; a wall was installed separating the computed tomography scan area from the MRI area.	N
4. Ensure MRI staff comply with local policy and the manufacturer's guidelines regarding use of the ferromagnetic detector.	The MRI Safety Officer revised MRI safety policy based on the manufacturer's guidelines. MRI technologists were trained on proper use of the detector.	N
5. Conduct emergency code drills in MRI areas.	Emergency code drills are conducted quarterly.	N
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6. Ensure Nursing Service representatives attend EOC rounds.	Nursing Service assigned a registered nurse representative and two alternate staff members to ensure participation in EOC rounds.	N
7. Conduct fire drills in accordance with National Fire Protection Association requirements.	Fire drills are being conducted once per shift per quarter in each building defined as health care occupancy.	N

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8. Ensure locked inpatient MH unit employees and members of the Multidisciplinary Safety Inspection Team receive required training on environmental hazards that represent a threat to suicidal patients.	All staff must complete this training, and it has been added to the Talent Management System. Compliance rates are at 99 percent.	N
4 0		
9. Develop a process to accurately track compliance with life support training.	The Talent Management System now tracks Advanced Cardiac Life Support training requirements. Compliance is at 99 percent.	N
10. Ensure the Medical Records Committee monitors the use of the copy and paste functions.	Reporting on copy and paste functions was added as a standing agenda item to the Medical Records Committee.	N
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11. Ensure clinicians document all required influenza vaccine elements.	Employee education was provided to all nurses, and nurses signed a document to verify that they understood expectations for documentation requirements for influenza vaccines in the Bar Code Medication Administration system.	N

VHA Satisfaction Surveys

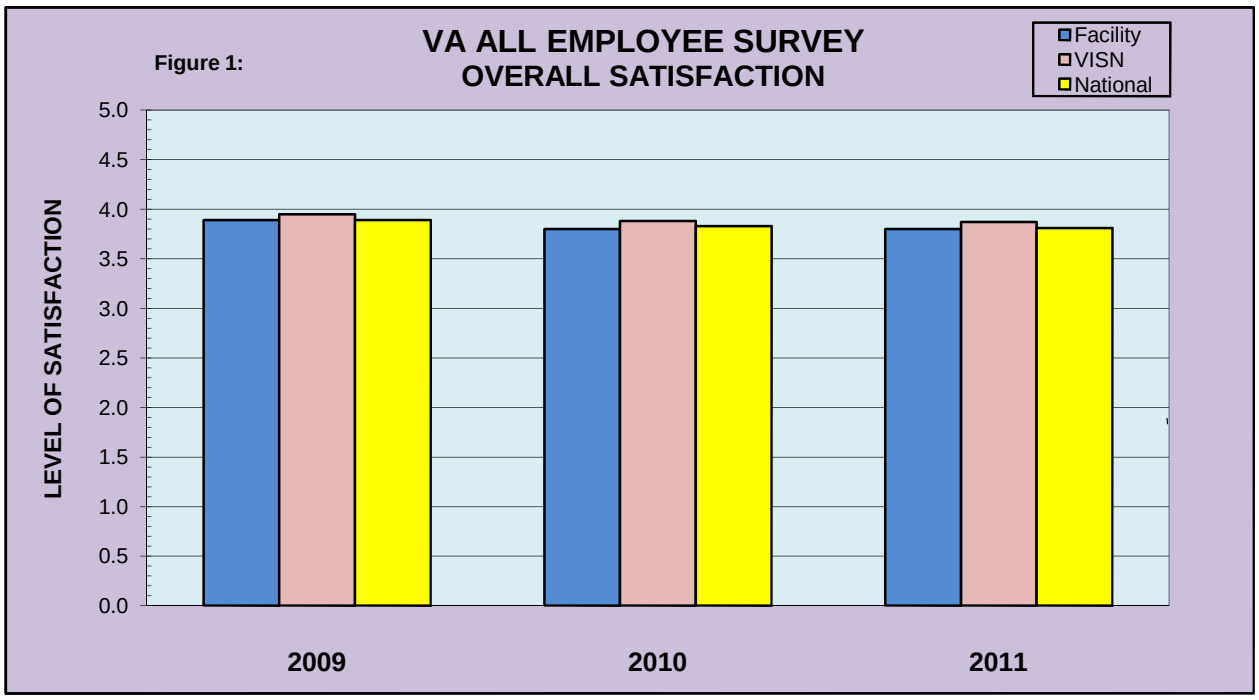
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall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

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	68.0	61.7	63.4	63.1	65.0	60.3
VISN	64.7	56.4	68.1	56.6	58.2	55.6
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[8] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[9]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.5	9.7	9.3	20.1	26.0	19.0
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[8] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[9] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 01/31/2012

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

Subject: **CAP Review of the West Palm Beach VA Medical Center, West Palm Beach, FL**

To: Director, Bay Pines Regional 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 West Palm Beach Medical Center, West Palm Beach, Florida.

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

Thank you,

Nevin M. Weaver

Nevin M. Weaver, FACHE

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 01/27/2012

From: Acting Director, West Palm Beach VA Medical Center (548/00)

Subject: **CAP Review of the West Palm Beach VA Medical Center, West Palm Beach, FL**

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

Thank you for completing the site visit on December 5–9th, 2011. I have reviewed this report and concur with the findings. Actions will be taken to correct the recommendations made.

Thank you again.

Deepak Mandi, MD

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that the Nursing Service MSDS inventory list and hazardous material information binder is current and complete and that staff are trained on how to access the electronic MSDS program.

Concur

Target date for completion: February 29, 2012

All MSDS binders were removed from all units as of 1/30/2012. To ensure the MSDS book is maintained and to ensure access to a MSDS book that is current, the book will be stored at one centralized location in the Nursing Office as per MCM. The single copy of the Nursing Service MSDS was reviewed and updated by the Safety Officer on 1/23/2012. The Safety Officer will provide education on accessing MSDS online at Reusable Medical Equipment Committee by 2/9/12 and Nurse Executive Board (NEB) by 2/14/12. The Safety Officer will provide MSDS training class on 2/17/12 and 2/18/2012 for Nurse Managers and/or designees. An all employee message from Safety outlining directions on how to access the on-line MSDS was sent out on 1/30/2012. A laminated Safety Poster with directions on how to access MSDS on-line will be posted at all Nurses Stations by 02/29/12 to reinforce the education in the e-mail.

Recommendation 2. We recommended that processes be strengthened to ensure that testing is performed on CLC electronic elopement prevention systems every 24 hours.

Concur and request to close

Target date for completion: January 27, 2012

Wanderguard testing was added to Clinical Alarm Setting Checklist to be verified daily. Nurses were informed during the site visit of the expectation to monitor and document daily. The Nurse Manager will randomly check to confirm documentation is complete. A random check performed on 1/27/12 by Quality Management confirmed that daily testing was documented for January 2012.

Recommendation 3. We recommended that processes be strengthened to ensure that medications, chemicals, and solutions on the dialysis unit are properly secured and that

clean and dirty supplies on the locked inpatient MH unit and the dialysis unit are properly stored and that dirty supplies are properly discarded.

Concur

Target date for completion: February 2, 2012

Dialysis Unit:

A process change was implemented where the dialysis solutions are not stored on the side of the dialysis machines or in front of the Nurses Station unsecured. A dedicated cart to hold chemicals after mixing was purchased and this cart is stored in a closet when it is not being used to transport the jugs. A work order was placed to install a lock on the closet to ensure the mixed solutions are properly secured. Nurses and techs were re-educated on expectations to secure medication and solutions and discard used supplies properly during the week of 12/12/2012. The Nurse Manager will complete random rounds daily Monday-Friday to monitor compliance. EOC Rounds and Tracer Activities will monitor proper and secure storage.

Mental Health Unit:

At the time of the site survey, staff was educated on expectations to place clean and dirty supplies into the correct storage area and doors are locked to maintain security. Dirty supplies are to be discarded in the proper bins to maintain safety and a clean environment. The Nurse Manager will randomly round on the unit Monday–Friday to ensure items are stored properly and under lock and supplies that should be discarded are discarded properly. Education will be provided as needed. Supply closet separation of dirty and clean and cleanliness with dirty supplies discarded properly will be reviewed during EOC Rounds and tracer activities. Deficiencies will be identified and reported to the Nurse Manager for corrective action.

Recommendation 4. We recommended that processes be strengthened to ensure that Case Managers are appropriately assigned to polytrauma outpatients and that interdisciplinary teams develop treatment plans that contain all required elements.

Concur

Target date for completion: March 1, 2012:

A focus group representing all Services impacted by guidelines outlined in Directive 2009-028 met on 1/20/2012 to confirm identified Polytrauma team members and obstacles to implement all criteria in the Directive. The Polytrauma Team will meet weekly starting 1/27/12. This will continue to 3/1/12 when the program will be assessed to ensure all aspects are functioning well. Based on the assessment the team will determine if weekly meetings can be decreased to bi-weekly. Roles, responsibilities and expectations of all team members are being defined and will be implemented by 2/24/2012. A Treatment Plan template will be developed that includes all defined elements to ensure consistent documentation is captured. As of 1/23/2012, the Team

Leader, OEF/OIF Program Manager and AO of PM&R are participating in the newly devised VISN 8 monthly Poly Trauma System of Care Conference Call for educational purposes communicating updated information and as a referendum to ask questions and share best practices. The first Interdisciplinary Team Meeting to complete the required documentation will be implemented no later than 3/1/2012.

Recommendation 5. We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

Concur

Target date for completion: February 24, 2012

The QUADRAD, Team Leader and the Service Chiefs where FTEE is impacted were part of the focus group that met on 1/20/12 to determine who would be representing the roles defined in Directive 2009-028. The Team Leader of the Polytrauma Team will provide oversight to ensure all roles are consistently maintained per Directive. Beginning on 2/24/12, any failure to meet Polytrauma Team role expectations will be reported monthly by the Team Leader to the respective Service Chief, the COS and Director. To support evidence of sustainability for the actions implemented, quarterly status report will be submitted by the Team Leader to Patient Care Review Committee (PCRC) up to Clinical Executive Board (CEB).

Recommendation 6. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: February 1, 2012

The Medicine-Primary Care Service Agreement for GI was rewritten and FOBT/FIT screening will no longer be used for CRC screening for most or all patients. Patients will be referred for screening colonoscopy beginning at age 50, every 10 years until the age of 75. Selected patients consulted to GI may be referred as indicated if they are between the ages of 75 and 85 consistent with US Preventive Task Force. Obtain concurrence with Medicine, Primary Care, and Chief of Staff, and implement. Staff was informed of the change in process on 1/19/2012. The service agreement will be fully implemented on 02/1/2012 and with the process change patients with positive CRC screening are no longer referred for a diagnostic test eliminating a wait time to track. All patients will be offered a primary referral for the diagnostic test, which is screening colonoscopy. All orders written for future triple FOBT card dissemination will be reviewed and removed from the pending list. All GI providers have been educated and will refrain from documenting annual FOBT requirements in their notes so PC providers will not be obligated to order them.

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians screen patients for tetanus vaccinations upon admission and at clinic visits.

Concur

Target date for completion: May 30, 2012

Inpatient Admissions:

The Advanced Practice Nurse for inpatient Medicine will submit a request to Medical Record Committee in February 2012 to add a button to the Admission template: Last tetanus vaccination date with a reminder to consider revaccination unless contraindicated at this time. An e-mail was sent to all Medicine Providers on 1/26/12 outlining expectations to address tetanus vaccination consideration at the time of admission as a short term fix until template modification is implemented. The Associate Chief of Medicine will provide reinforcement of education and outline expectations at Medicine Staff Meeting on 2/1/2012 for providers to address tetanus vaccination consideration at the time of admission as a short term fix until template modification is implemented. The audit analysis for compliance will be added to the quarterly pertinence review report submitted to Medical Record Committee as a standing agenda item.

Clinic Patients:

A request will be submitted in February 2012, to create a outpatient clinical reminder. The clinical reminder is expected to be implemented in March 2012 and when patients present to PC, Nursing will identify the requirement for tetanus revaccination. The Nurse Managers (NM) will educate and outline expectations for all PC nursing staff when the clinical reminder is implemented. NMs will run clinical reminder compliance reports weekly to identify compliance. Re-education will be provided as needed. Weekly clinical reminder compliance reports will be aggregated and reported monthly at Nursing staff meetings which will be supported in the minutes.

Recommendation 8. We recommended that processes be strengthened to ensure that clinicians document all required pneumococcal and tetanus vaccination administration elements and that compliance be monitored.

Concur

Target date for completion: May 30, 2012

A reminder dialogue will be completed by March 2012 to ensure documentation by providers is supported in the electronic medical record. Nurse Managers will run clinical reminder compliance reports and verify compliance with documentation weekly. The report will be submitted to Medicine and Primary Care and the Services and re-education will be provided to providers as needed. Weekly clinical reminder compliance reports will be aggregated and reported monthly at Medicine and Primary Care staff meetings which will be supported in the minutes.

Recommendation 9. We recommended that processes be strengthened to ensure that the Peer Review Committee is notified in writing when corrective actions are completed.

Concur and request to close

Target date for completion: January 9, 2012

Service Chiefs have always been required to respond in writing when actions are completed. The Peer Review Coordinator will continue to aggregate all responses into a tracking grid and use that for reporting purposes. The grid will be submitted as a standing agenda item at the Peer Review Committee (PRC) meeting and attached to the PRC minutes as of 01/09/2012.

Recommendation 10. We recommended that processes be strengthened to ensure that all clinicians caring for patients receiving moderate sedation maintain current training.

Concur

Target date for completion: February 29, 2012

Education Service configured a Talent Management System (TMS) report identifying only those Providers that have moderate sedation privileges and Registered Nurses who are deemed competent to administer moderate sedation identifying the dates for ACLS certification and Moderate Sedation TMS Training every two years. Education Service requested the Medical Staff Office to identify those providers in Medicine, Imaging and Surgery Service that have current moderate sedation privileges and they were added to the TMS report structure. Education Service requested that Nursing identify all RNs that have current competencies for administering moderate sedation and they were added to the TMS report structure. Education Service will request a monthly update from Medicine, Surgery, Imaging and Nursing as to who is added or removed from the current list and then will revise the TMS Report. After the revision, Education Service will then run a current report each month and forward to the Service for service-level action. Education Service has a member on the Moderate Sedation Committee and the TMS report was added as a standing agenda item at the quarterly Moderate Sedation Meeting as of 1/10/2012 which reports up to Patient Care Review Committee (PCRC) and up to Clinical Executive Board (CEB).

Recommendation 11. We recommended that the facility complete the steps to receive PRRC designation by the OMHS.

Concur and request to close

Target date for completion: December 26, 2012

WPB VAMC received formal designation of its Health and Recovery Program as a PRRC December 16, 2011, from OMHS.

OIG Contact and Staff Acknowledgments

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