



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 08-01331-32

Combined Assessment Program Review of the West Palm Beach VA Medical Center West Palm Beach, Florida



December 2, 2008

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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Table of Contents

	Page
Executive Summary	i
Introduction	1
Profile.....	1
Objectives and Scope	1
Organizational Strength	3
Results	3
Review Activities With Recommendations	3
Environment of Care.....	3
Quality Management	8
Pharmacy Operations.....	10
Review Activities Without Recommendations	12
Coordination of Care	12
Emergency Department.....	13
Medication Management	14
Patient Satisfaction.....	14
Staffing	16
Appendixes	
A. VISN Director Comments	17
B. Medical Center Director Comments.....	18
C. OIG Contact and Staff Acknowledgments	24
D. Report Distribution.....	25

Executive Summary

Introduction

During the week of July 21–25, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the West Palm Beach VA Medical Center (the medical center), West Palm Beach, 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 144 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:

- Emergency department (ED) utilization.

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

- Correct the electrical closet and the television and videocassette recorder (VCR) electrical cord conditions on the locked mental health unit (MHU).
- Complete a risk assessment and action plan that addresses the environmental hazards in the room designated for mental health patients in the ED.
- Require community living center (CLC)¹ nursing staff to comply with infection control (IC) guidelines for patients on isolation precautions.
- Require that contaminated equipment is clearly identified and stored separately from clean supplies.
- Ensure that the security of confidential patient information is maintained.
- Ensure that the security of housekeeping closets, housekeeping carts, and cleaning solutions is maintained.
- Assure privacy for all patients in the chemotherapy unit.
- Perform weekly preventive maintenance (PM) inspections of the WanderGuard® system and document results.
- Ensure that clinicians complete peer reviews in the required timeframes and present trending and analysis

¹ A CLC (formerly called a nursing home care unit) provides person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

data to the Clinical Executive Board (CEB), as required by VHA policy.

- Evaluate adverse events that could potentially require disclosure.
- Assure that all controlled substances inspectors (CSIs) complete training and competency reviews and that the results are documented.
- Assure that clinical pharmacists complete monthly polypharmacy reviews on all CLC patients, as required by The Joint Commission (the JC).

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

- Coordination of Care.
- ED.
- Medication Management.
- Patient Satisfaction.
- Staffing.

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 17–23, 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 West Palm Beach, FL, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics (CBOCs) in Boca Raton, Delray Beach, Ft. Pierce, Okeechobee, Stuart, and Vero Beach, FL. Also, there is a post-traumatic stress disorder clinic in Port St. Lucie, FL. The medical center is part of VISN 8 and serves a veteran population of about 188,500 throughout Indian River, Okeechobee, St. Lucie, Martin, Glades, Hendry, and Palm Beach counties in Florida.

Programs. The medical center provides medical, surgical, and inpatient and outpatient psychiatric services. It also provides community residential care, adult day care, respite care, hospice care, and CLC care. The medical center has 252 hospital beds and 120 CLC beds.

Affiliations and Research. The medical center is affiliated with the University of Miami's Leonard M. Miller School of Medicine, Nova Southeastern University's College of Osteopathic Medicine and College of Dental Medicine, Columbia Hospital, and the Palm Beach County Health Department. It supports training programs for medical residents and nursing. In fiscal year (FY) 2007, the medical center did not have any research projects.

Resources. In FY 2007, medical care expenditures totaled \$201.9 million. The FY 2008 medical care budget was \$277 million. FY 2008 staffing was 1,961 full-time employee equivalents (FTE), including 176.5 physician and 364 nursing FTE.

Workload. In FY 2007, the medical center treated 63,194 unique patients and provided 398,197 inpatient days in the hospital and 37,140 inpatient days in the CLC. The inpatient care workload totaled 6,916 discharges, and the average daily census, including CLC patients, was 203. Outpatient workload totaled 550,047 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.
- 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:

- Coordination of Care.
- ED.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- Pharmacy Operations.
- QM.
- Staffing.

The review covered medical center operations for FY 2007 and FY 2008 through July 25, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, West Palm Beach, Florida, Report No. 05-02813-32, December 6, 2005*). 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 144 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

Emergency Department Utilization

To improve access and timeliness in the ED, the medical center implemented several actions which have had positive results. For example, emergency nurses were trained to use the five-level Emergency Severity Index (ESI) triage system, which categorizes patients' conditions and health care needs on a continuum from emergent to routine. Managers also took action to give primary care providers one or two unscheduled appointment slots daily. In April 2007, ED staff started referring patients with non-emergent ESI classifications to primary care providers using the unscheduled appointment slots. These actions have resulted in a decrease in the number of patients waiting in the ED longer than 6 hours from 495 in the 2nd quarter of FY 2007 to 163 in the 2nd quarter of FY 2008.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether Veterans Health Administration (VHA) medical centers maintain a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and JC standards.

We inspected the acute inpatient medical unit (6A) and surgical unit (7A), the medical/surgical intensive care unit (ICU), the locked MHU, the CLC, the chemotherapy unit, the ED, the blind rehabilitation unit, and the primary care clinics. We found that the medical center was generally clean and well maintained and had corrected the EOC findings from our prior CAP review. The IC program monitored exposures and reported data to clinicians for implementation of quality improvements. However, we identified deficiencies related

to patient safety on the locked MHU and in the ED, IC precautions, security of patient information, security of housekeeping closets and carts, patient privacy, and testing of the WanderGuard® alarm system.

Patient Safety on the Locked Mental Health Unit. The medical center's Multidisciplinary Safety Inspection Team (MSIT) conducted rounds on the locked MHU and completed the Mental Health Environment of Care Checklist,² as required by VHA. Managers presented us with plans that addressed all identified hazards. However, the television and VCR in the day room had electrical cords that exceeded the 12-inch limit. These items had not been identified in the risk assessment. In addition, we found an unlocked electrical closet, which could pose a risk of serious harm to patients.

Managers implemented an interim life safety measure of patient observations every 30 minutes to minimize the risk for harm until corrective actions on the checklist could be completed. We reviewed documentation for July 1–25, 2008, and found that these 30-minute observations were not consistently documented.

Patient Safety in the Emergency Department. We found that the room in the ED that was designated for mental health patients was not assessed for environmental hazards. We identified several possible anchor points, such as open grab bars, a faucet, and a toilet paper holder. We also found a call bell cord in the shower that exceeded the 12-inch limit. Although we were told that mental health patients placed in this room were on one-to-one observation, the environment increased the risk for negative patient outcomes.

Infection Control Precautions. Two CLC nurses did not follow IC procedures for patients on contact precautions, as prescribed by medical center policy.³ We observed both nurses entering an isolation room without putting on gowns. We also observed one nurse taking a portable blood pressure monitor into the isolation room and leaving the room without washing her hands. Staff should follow IC policies and procedures to protect patients from hospital-acquired infections.

² Tool used for the purpose of assessing environmental risks and eliminating factors that could contribute to the attempted suicide or suicide of a patient or harm to staff members.

³ Medical Center Memorandum 548-99-262, *Isolation and Precautions for Infection Control*, June 2, 2007.

We found an imaging machine and an electrocardiography machine stored in a clean supply room on the CLC. We were informed by managers that space on the unit was limited and that there was no place to store equipment. Although lack of adequate space may have been an issue, contaminated equipment should be identified and stored separately to avoid the risk of infection. Managers removed the equipment from the supply room while we were onsite.

Security of Patient Information. Four computers with patient information visible on the monitors were left unattended in the urology clinic treatment room and at nursing stations in the ICU, the MHU, and the ED. The security of confidential patient information is required under the Health Insurance Portability and Accountability Act.

Security of Housekeeping Closets and Carts. In the CLC, we found an unattended housekeeping cart with accessible cleaning solutions. This could pose a hazard to patients. Also, we found an unlocked housekeeping closet on the blind rehabilitation unit. JC standards require hospitals to provide a safe environment and to properly handle and store hazardous chemicals. Managers corrected these deficiencies while we were onsite.

Patient Privacy. The chemotherapy unit did not have privacy curtains for all cubicles. We also found that not all recliners used for patient care were separated by curtains nor were partitions available to provide privacy for patients. JC standards require hospitals to respect each patient's need for privacy.

Testing of the WanderGuard® Alarm System. We found that weekly PM inspections of the CLC WanderGuard® system were not completed according to medical center PM procedures. We reviewed the WanderGuard® PM history for the period January 8–July 2, 2008, and found that inspections were not conducted weekly, as required. Routine PM testing of the WanderGuard® system is necessary to ensure the safety of CLC patients.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director corrects the electrical closet and the television and VCR electrical cord conditions on the locked MHU.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the television and videocassette cord conditions have been corrected. Staff were educated on securing all electrical closets and other locked areas to ensure patient and staff safety and equipment security. Electrical cords and electrical closets will be monitored routinely. 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 the MSIT to complete a risk assessment and action plan to address the environmental hazards in the room designated for mental health patients in the ED.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the risk assessment was completed and that corrective actions have been planned to resolve the identified conditions. The planned actions are acceptable, and we will follow up until they are completed.

Recommendation 3

We recommended that the VISN Director ensure that the Medical Center Director requires CLC nursing staff to comply with IC guidelines for patients on isolation precautions.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that an intensive educational program was developed for CLC staff. The program includes hand hygiene, isolation precautions, and the methicillin-resistant *Staphylococcus aureus* initiative. The planned action is acceptable, and we will follow up until staff training is completed.

Recommendation 4

We recommended that the VISN Director ensure that the Medical Center Director requires that contaminated equipment is clearly identified and stored separately from clean supplies.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the contaminated equipment was removed from the clean supply room during the CAP review. Nursing and Environmental Management Service (EMS) staff were re-educated on the importance of isolating clean supplies and equipment from dirty supplies and equipment. Compliance will be monitored

by supervisors, during environmental rounds, and through internal tracers. The planned actions are acceptable, and we will follow up until the medical center's internal monitors show consistent compliance.

Recommendation 5

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 agreed with the finding and recommendation and reported that staff are educated on the importance of ensuring the confidentiality of patient information and about computer security during mandatory new employee education. All computer workstations automatically lock after 15 minutes, and all staff review the rules of behavior annually. Ongoing mandatory educational programs reinforce importance, and staff compliance is tracked and reported to leadership. Additional training needs will be identified through increased monitoring. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 6

We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that the security of housekeeping closets, housekeeping carts, and cleaning solutions is maintained.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that EMS staff have completed additional training that outlined the expectations for maintaining security of housekeeping closets and carts and all cleaning solutions. Compliance will be monitored by supervisors. The planned actions are acceptable, and we will follow up until the medical center's internal monitors show consistent compliance.

Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director takes action to assure privacy for all patients on the chemotherapy unit.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that each chemotherapy chair currently has a privacy screen. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 8

We recommended that the VISN Director ensure that the Medical Center Director requires staff to conduct and document weekly PM inspections of the WanderGuard® system.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that PM checks on the WanderGuard® system are scheduled to be completed weekly. In addition, staff were re-educated on proper documentation of PM checks. The planned actions are acceptable, and we will follow up 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. To evaluate QM processes, we interviewed senior managers and reviewed relevant documents and committee minutes.

We found that medical center managers supported QM efforts and that appropriate review structures were in place for 13 of the 15 program activities reviewed. However, we identified two areas that needed strengthening.

Peer Review. The medical center's peer review process did not comply with certain aspects of VHA policy.⁴ Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. We evaluated peer review activities conducted during FY 2007 and the 1st quarter of FY 2008 and identified the following issues:

- The medical center did not complete peer reviews within the required timeframes. We noted that only 25 of 81 peer reviews (31 percent) met the initial 45-day deadline and that only 65 of 81 peer reviews (80 percent) met the 120-day completion deadline.
- The medical center's Peer Review Committee (PRC) did not submit any quarterly reports—which should have

⁴ VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004, and VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

included trending and analysis—to the CEB in FY 2007. The CEB has oversight responsibility for peer review activities and outcomes. Furthermore, the PRC did not submit the 1st and 2nd quarter FY 2008 reports to the CEB until May 2008.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. Peer reviews and data evaluation should be conducted in accordance with VHA policy to ensure that providers perform according to accepted community standards and that improvement actions are taken when indicated.

While we were onsite, managers explained that staffing problems had hindered their efforts to manage all program aspects and that they have implemented corrective measures.

Adverse Event Disclosure. The medical center did not evaluate all cases for possible disclosure, as required by VHA⁵ and local policy. Clinical disclosure is an informal process to discuss harmful events with patients and/or their families; physicians document clinical disclosure in progress notes. Institutional disclosure is a more formal process used in cases of serious injury, death, or potential legal liability and includes an apology, compensation information, and procedures available to request compensation.

The medical center had disclosed two cases within the past 12 months. However, we identified two additional cases involving adverse events that occurred in FY 2007 and the 1st quarter of FY 2008 that had not been evaluated for disclosure. Without a defined process for adequate evaluation of events that could potentially require disclosure, managers could not be assured that patients received important medical and legal information needed to make decisions.

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews and the presentation of trending and analysis data to the CEB, as required by VHA policy.

⁵ VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that analysis of FY 2008 data shows consistent improvement in the timeliness of completion. Peer review is now a quarterly CEB agenda item. The planned actions are acceptable, and we will follow up until they are completed.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate adverse events that could potentially require disclosure.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that since February 2008, the Patient Incident Worksheet (PIW) has included a trigger question that asks whether the incident should be considered for disclosure. The Chief of Staff reviews PIWs to evaluate the need for disclosure. The PIW tracking system has been reviewed and improved. To improve documentation for disclosures, a proposal has been made to add a clinical disclosure template to the institutional disclosure template currently in use. The planned actions are acceptable, and we will follow up until they are completed.

**Pharmacy
Operations**

The purposes of this review were to evaluate the pharmacies' internal physical environments and to determine whether the medical center had adequate controls to ensure the security and proper management of controlled substances. We also evaluated whether clinical managers had processes in place to monitor patients who were prescribed multiple medications.

We reviewed VHA regulations⁶ governing pharmacy and controlled substances security, and we assessed whether the medical center's policies and practices were consistent with these regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate Pharmacy Service and Police and Security Service personnel as necessary. Additionally, we reviewed policies and procedures and interviewed appropriate personnel to determine whether

⁶ VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy Service*, June 27, 2006.

clinical pharmacists monitored patients prescribed multiple medications.

Our review showed that the medical center had appropriate policies and procedures to ensure the security of the pharmacies. Managers reported all controlled substances diversions or suspected diversions to the OIG. The pharmacies' internal physical environments were secure, clean, and well maintained. However, the following conditions required management attention:

Controlled Substances Inspections. Controlled substances inspections were conducted according to VHA regulations. However, managers could not provide documentation that 2 of the 25 CSIs had completed the necessary training in the past year or that the competencies of two other CSIs had been evaluated. Proper documentation of CSI training and competency improves the credibility of the controlled substances inspection process.

Polypharmacy. Clinical pharmacists did not always review CLC patients' medications for polypharmacy every 30 days, as required by the JC. Pharmacological regimens involving multiple medications are often necessary to prevent and treat disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.⁷ Literature suggests that elderly patients are among the most vulnerable for polypharmacy.⁸

We found that 5 of 10 CLC patients' medical records did not reflect that clinical pharmacists had evaluated the patients' medications for possible polypharmacy. The JC requires that pharmacists complete medication reviews monthly for CLC patients; however, we found that in these cases, clinical pharmacists were late in completing reviews or missed

⁷ Yvette C. Terrie, BSPHarm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times*, December 2004.

⁸ Terrie, *Pharmacy Times*, December 2004.

monthly reviews altogether. Timely polypharmacy reviews are necessary to ensure patient safety.

Recommendation 11

We recommended that the VISN Director ensure that the Medical Center Director requires that all CSIs complete appropriate training and competency reviews and that the results are documented.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that all 21 CSIs have completed both training and competencies. A process has been implemented for all inspectors to complete annual training in September to ensure compliance for the upcoming year. The CSI Coordinator will verify that certificates and competencies are current before CSIs are assigned inspection dates. The corrective actions are acceptable, and we will follow up until the medical center's internal monitors confirm completion and documentation of the September training.

Recommendation 12

We recommended that the VISN Director ensure that the Medical Center Director requires that clinical pharmacists complete monthly polypharmacy reviews on all CLC patients, as required by the JC.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the Pharmacy Service instituted a weekly chart review action that will identify all patients due for a polypharmacy review during the upcoming week. The Pharmacy Service will monitor the process and report to the Medication Use Committee monthly. The corrective actions 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 intra-facility (ward-to-ward) transfers, consults, and discharges were coordinated appropriately and met VHA and JC standards. We reviewed 12 records of recently discharged patients and found that the discharge orders and summaries were generally consistent and that patient education concerning discharge instructions was well documented. A review of 15 records demonstrated that all consults were responded to in a timely fashion.

We reviewed 13 patient transfers within the medical center for evidence of communication between sending and receiving physicians and nursing staff. Care was transferred to another physician in seven cases. However, physician-to-physician communication was documented in only two of those seven records. While onsite, we discovered that an existing patient transfer template in the electronic medical record was not functional. It was repaired during our visit. Therefore, we made no recommendations.

Emergency Department

The purpose of this review was to evaluate whether medical center EDs complied with VHA guidelines related to hours of operation, clinical capability (including management of patients with acute mental health conditions and patients transferred to other facilities), staffing adequacy, and staff competency. In addition, we inspected the medical center's ED and triage environments for cleanliness and safety.

The medical center's ED is open 24 hours per day, 7 days per week, as required for an ED. The ED is located within the main hospital building, and the emergency services provided are within the medical center's patient care capabilities. In addition, the medical center has an appropriate policy for managing patients whose care may exceed the medical center's capability and has a Memorandum of Understanding with a local private facility.

We reviewed the medical records of five patients who presented to the ED with acute mental health conditions, and in all cases, we found that patients were managed appropriately. In addition, we determined that three randomly selected inter-facility patient transfers complied with medical center policy.

We reviewed the ED nurse staffing plan and duty schedules and determined that managers had consistently followed their established staffing guidelines for allocating nursing resources. We also determined that initial and ongoing nursing competency assessments were adequately documented.

In addition, we found that physicians' delineated clinical privileges were current, clearly defined, and readily available to the ED staff for reference. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes ordering, administering, and monitoring medications. We reviewed selected medication management processes in the acute inpatient medical and surgical units, the ICU, the locked MHU, and the CLC. Also, we reviewed 30 patients' medical records for documentation of pain medication effectiveness.

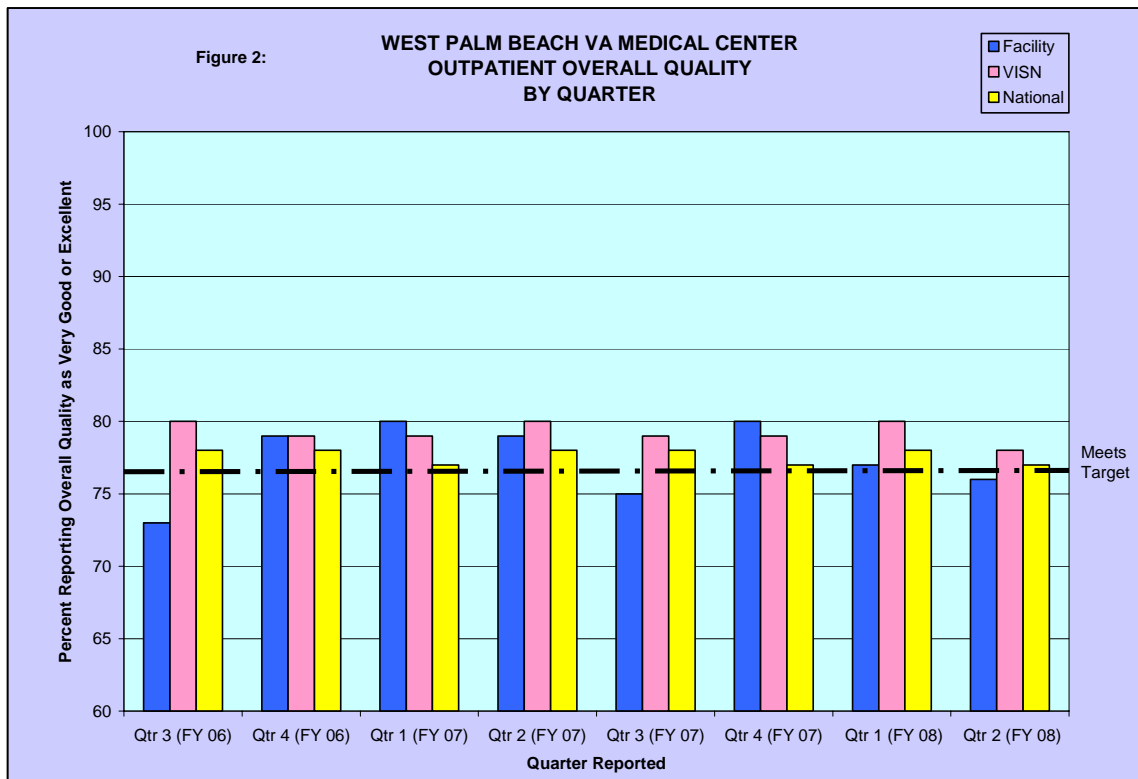
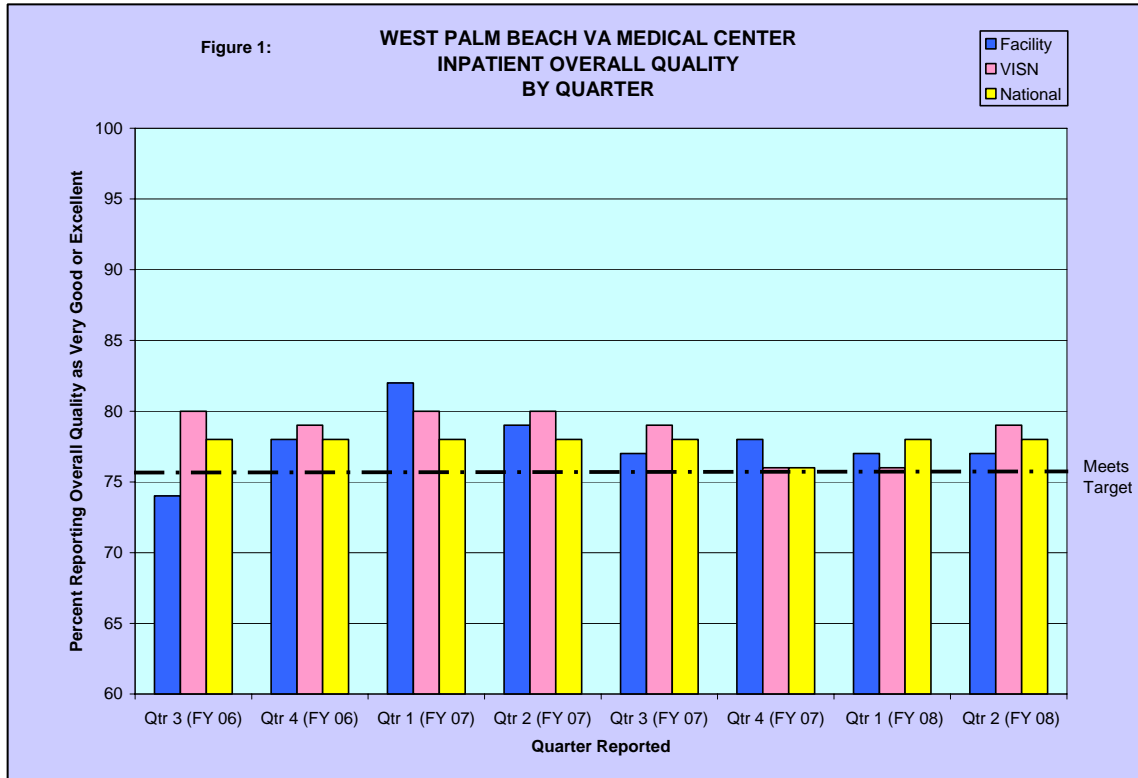
We noted that all patients that received pain medications were assessed post-medication administration and that effectiveness was documented in the electronic medical record, as required by medical center policy. We found adequate management of medications brought into the medical center by patients or their families and appropriate use of patient armbands to correctly identify patients prior to medication administration. 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 survey data to improve patient care.

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

Figures 1 and 2 on the next page show the medical center's patient satisfaction performance measure results for inpatients and outpatients, respectively. The medical center met or exceeded the established target for inpatient overall quality for 7 of the last 8 quarters. However, the medical center only met the established target for outpatient overall quality for 5 of the last 8 quarters.



The medical center had a multidisciplinary Customer Service Committee that analyzed and reported SHEP survey results. The committee identified opportunities to improve patient satisfaction by increasing access to care and decreasing wait times in the outpatient clinics. This was accomplished by hiring new contract providers for three of the outpatient clinics. Managers also plan additional education efforts for the medical center's advanced clinic access process. Therefore, we made no recommendations.

Staffing

The purpose of this review was to evaluate whether the medical center had developed comprehensive nurse staffing guidelines and whether the guidelines had been met. We found that the medical center had developed guidelines using hours per patient day (HPPD),⁹ professional standards, and national guidelines.

We reviewed five inpatient units for 20 total shifts. We found that the medical center's guidelines for nurse staffing were generally met in all areas reviewed and that specific actions had been taken to ensure safe patient care, including the use of intermittent nurses¹⁰ and overtime and the sharing of staff between units. Therefore, we made no recommendations.

⁹ Nursing care HPPD refers to the number of nursing care hours relative to the patient workload. This measure was developed by the American Nurses Association for the National Database of Nursing Quality Indicators.

¹⁰ Nursing staff that are not full- or part-time employees but work when needed.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September, 23, 2008

From: Director, VA Sunshine Healthcare Network 8 (10N8)

Subject: **Combined Assessment Program Review of the VA
Medical Center, West Palm Beach, Florida**

To: Associate Director, St. Petersburg 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 VA Medical Center, West Palm Beach, Florida.
2. Corrective action plans have been established with planned 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: September, 23, 2008

From: Director, VA Medical Center, West Palm Beach, FL (584/00)

Subject: **Combined Assessment Program Review of the VA
Medical Center, West Palm Beach, Florida**

To: Director, VA Sunshine Healthcare Network 8 (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:)

Charleen Szabo

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 corrects the electrical closet and the television and VCR electrical cord conditions on the locked MHU.

Concur

Target Date: July 24, 2008 (completed)

The television and videocassette cord lengths were corrected (less than 12 inches) on July 24, 2008. Staff was educated on securing all electrical closets and other locked areas to ensure patient and staff safety as well as equipment security on July 24, 2008. Electrical cords and electrical closets will be monitored during quarterly environmental rounds and other internal reviews including the quarterly rounds conducted using the MHU Environment of Care checklist. The Nurse Manager monitors on rounds daily.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires the MSIT to complete a risk assessment and action plan to address the environmental hazards in the room designated for mental health patients in the ED.

Concur

Target Date: November 14, 2008

The risk assessment was completed, and all environmental physical improvements were identified with a completion schedule dependent on the type of fix. All simple fixes (i.e., eliminating the anchor point by adding a solid barrier to hand rail, removing the paper towel and soap dispensers) were completed August 8, 2008. The more complicated fixes have been prioritized and scheduled to expedite completion. All necessary equipment and materials were ordered the first week in August. Construction to eliminate all identified risks is expected to be completed by November 14, 2008. All ED patients that are identified to be high risk are placed on 1:1 status for patient safety.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires CLC nursing staff to comply with IC guidelines for patients on isolation precautions.

Concur

Target Date: October 3, 2008

An intensive educational program was developed by the IC and MRSA Coordinator for the CLC staff (Nursing, Medical Administration Service, and EMS) to include hand hygiene, isolation precautions, and the MRSA initiative. This 1.5 hour educational session will be given six times to cover all shifts. The kick off date was September 15, 2008, and the last session will be completed on October 3, 2008. Monitoring will be conducted through data pulls on MRSA swabbing compliance, visual inspections during environmental rounds, and internal tracers.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that contaminated equipment is clearly identified and stored separately from clean supplies.

Concur

Target Date: August 29, 2008 (complete)

As noted in the report, the contaminated equipment was removed from the Clean Supply Room during the CAP Review. Re-education was provided to Nursing on July 25, 2008 and EMS staff on August 29, 2008, on the importance of isolating clean from dirty supplies and equipment for patient and staff safety. This will be monitored by supervisors and during environmental rounds and internal tracers.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of confidential patient information is maintained.

Concur

Target Date: October 1, 2008

Staff is initially educated on the importance of ensuring patient information confidentiality and computer security during mandatory new employee education (completed within 30 days) of the station start date. The national rules of behavior are reviewed and electronically signed annually by all staff. Importance is reinforced through ongoing mandatory educational programs such as VA Cyber Security Awareness and VA Privacy Awareness Training offered through the VA Learning Management System, and staff compliance is tracked by service

supervisors and reported to leadership. The Information Security Officer (ISO), Chief Information Officer, and Privacy Officer provide ongoing face to face training for all Services. All computer work stations automatically lock after fifteen (15) minutes. When questioned, staff articulates the importance of paper and computer confidentiality and security. Increased monitoring by the ISO, supervisors, and internal tracers will identify outliers to identify the need for additional 1:1 training.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that the security of housekeeping closets, housekeeping carts, and cleaning solutions is maintained.

Concur

Target Date: August 29, 2008 (complete)

EMS staff completed additional training on August 29, 2008, outlining the expectations for maintaining security of housekeeping closets, carts, and all solutions. Compliance will be monitored by supervisors and during environmental rounds and internal tracers.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director takes action to assure privacy for all patients on the chemotherapy unit.

Concur

Target Date: August 8, 2008 (complete)

The outpatient chemotherapy unit was evaluated and additional curtains were added on August 8, 2008, so that each lounge currently has a privacy screen.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires staff to conduct and document weekly PM inspections of the WanderGuard® system.

Concur

Target Date: July 28, 2008 (complete)

Preventative maintenance checks on the WanderGuard® system are scheduled to be completed weekly for patient safety. An internal audit indicated checks were done, but the documentation was not completed accurately. On July 28, 2008, staff received re-education on data entry and future documentation expectations. Also, on July 28, 2008, weekly

oversight was assigned to a Facilities Management Services supervisor to ensure future documentation compliance.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires timely completion of peer reviews and the presentation of trending and analysis data to the CEB, as required by VHA policy.

Concur

Target Date: September 9, 2008 (complete)

Analysis of FY 2008 data shows consistent improvement in 45 day and 120 day completion compliance with the overall number of peer reviews steadily increasing. To monitor the peer review process, a report is given every Monday to leadership at the morning report. Peer review reports have been completed and reported to the VISN as scheduled. Peer Review is now a quarterly agenda item for the CEB and was last presented August 5, 2008. The MCM for Preparing Meeting Minutes was revised on September 9, 2008, to include meeting agenda requirements. The policy now states that it is the recording secretary's responsibility to ensure all agenda items deferred for any reason will be carried over to the next agenda until the reporting requirement is satisfied to ensure consistent reporting being captured in all minutes.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that mechanisms are in place to adequately evaluate adverse events that could potentially require disclosure.

Concur

Target Date: October 1, 2008

As of February 2008, the PIW has included a trigger question that asks if this incident should be considered for disclosure. The OIG at time of survey felt that this was a good action and would improve compliance. PIWs are reviewed by the COS to evaluate the need for disclosure. The tracking system for PIWs has been reviewed and improved to identify the timeline involved and all actions taken. To improve documentation for disclosures, a proposal has been made to add a clinical disclosure template to the institutional disclosure template currently in use. This template will be presented to the Medical Record Review Committee on October 1, 2008, for approval, development, and implementation.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director requires that all CSIs complete

appropriate training and competency reviews and that the results are documented.

Concur

Target Date: September 23, 2008 (complete)

All 21 Controlled Substance Inspectors (CSI) have completed both the training and competencies as of September 23, 2008. The CSI Coordinator has also reviewed the competency form with each CSI individually and maintains a file of the forms. The CSI Coordinator verified that all twenty one files contain the training certificate and competency form for FY09 on September 23, 2008. An annual process has been implemented for all inspectors to complete the annual training in the month of September to ensure compliance for the upcoming year. All CSIs will be given a copy of their training certificate and competency form as a back up to the original file. The CSI Coordinator will verify the certificate and competencies are current and in the file before the CSI is assigned an inspection date.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical pharmacists complete monthly polypharmacy reviews on all CLC patients, as required by the JC.

Concur

Target Date: August 25, 2008 (complete)

The pharmacy instituted a weekly polypharmacy chart review action on August 25, 2008, that will identify all patients due for a polypharmacy review during the upcoming week. Pharmacy will monitor the process and report to the Medication Use Committee monthly.

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