Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02887-64

Healthcare Inspection

Quality of Care Issues
West Palm Beach VA Medical Center
West Palm Beach, Florida

December 18, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to an anonymous letter received by Florida Governor Rick Scott, who forwarded it to the OIG. The letter contained multiple allegations about the quality of care at the West Palm Beach VA Medical Center (facility), West Palm Beach, FL.

We did not substantiate that events related to patient falls, resulting in injury and the deaths of two patients, were not reported or investigated. However, we found that the investigation of one of the seven patient falls that we reviewed was not timely. Our review of the patients' electronic health records revealed that the care provided for the patients was appropriate.

We did not substantiate the allegation that a patient missed a scheduled chemotherapy treatment; however, completion of the patient's chemotherapy was delayed, and the incident was not reported to the Patient Safety Manager (PSM) as required.

We did not substantiate the allegation that a patient was inappropriately given medications during a cardiac arrest in the operating room or that the patient's death was not properly reported or investigated. While reviewing the circumstances of the cardiac arrest, however, we found that the correct progress note was not used to document the resuscitation event. As a result, the facility Risk Manager was unaware of the event and did not initiate a required review.

We substantiated the allegation that a patient had the wrong lens implant placed in his eye during cataract surgery because the operative team failed to properly perform the time-out process. The PSM was not notified of the incident immediately, as required, using the Critical Incident Tracking Notification system, and the case was not reviewed by the Morbidity and Mortality Committee until 6 months later, while we were onsite.

We did not substantiate the allegation that facility staff "covered up" or failed to disclose adverse events to Veterans Integrated Service Network (VISN) 8. Once the PSM was made aware of the patient safety concerns cited in the allegations, the incidents were reviewed and reported to VISN 8 as required by local, VISN, and Veterans Health Administration policy.

We found that local policy for reporting patient incidents and/or safety concerns was not being followed. The current process of reports going through layers of nursing management before reaching the PSM causes unnecessary delays and missed opportunities for early intervention.

Although not an allegation, we found that Quality Management Service has been chronically understaffed.

We recommended that the Facility Director ensure that patient safety incidents and concerns are reported promptly to the PSM and that the need for further review and/or

corrective actions is assessed initially by the PSM, that cardiac resuscitation events in the operating room are appropriately documented and reviewed, and that the Critical Incident Tracking Notification system recipient list includes the PSM. We also recommended that the Facility Director assess staffing in the Quality Management Service and take appropriate actions to meet the workload requirements.

Comments

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 10–14 for the Directors' comments.) We consider recommendation 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to an anonymous letter received by Florida Governor Rick Scott, who forwarded it to the OIG. The letter contained allegations concerning quality of care issues at the West Palm Beach VA Medical Center (facility), West Palm Beach, FL. The purpose of the review was to determine if the allegations had merit.

Background

The facility is a tertiary care facility with 181 acute care beds that provides a broad range of medical, surgical, and psychiatric inpatient care, as well as primary and specialty care outpatient services. The facility is part of Veterans Integrated Service Network (VISN) 8, and serves a veteran population of 56,677 unique patients.

Patient Safety

The VA National Center for Patient Safety (NCPS) collects and analyzes data from Veterans Health Administration (VHA) facilities, offers training and consultation to VHA medical facilities, and disseminates clinical guidelines and best practices to promote a culture of safety. VHA requires that every facility have a patient safety manager (PSM). Staff are encouraged to report unsafe conditions to the PSM, even if the conditions did not result in patient harm.[1] The PSM reviews the incident and assigns a safety assessment code (SAC) score that indicates the severity of the event and what further reviews are to be done. The SAC score is not to be determined by staff other than the PSM or Acting PSM. This information is then reviewed with the Chief of Staff, who determines whether further action is needed. The PSM enters the incident information, including the SAC score, into an NCPS database. The NCPS tracks, trends, and reports this data across VHA. VISN 8 further requires that PSMs do their initial assessment in a timely manner, and that serious incidents or injuries, such as a wrong implant surgery, be reviewed within 24 hours. Local policy requires that all incidents be reported to the PSM within 24 hours to 3 days, depending on the type and severity of the incident.

Once an assessment has been done, VHA policy states that PSMs are to initiate reviews to help determine what happened and how to prevent recurrence.[2] One type of review initiated by the PSM is the Root Cause Analysis (RCA). An RCA focuses more on systems and processes rather than individual performance and should identify changes that could be made in systems and processes to improve performance and reduce risks to patients.

[1] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
[2] Ibid.

VISN policy further requires that certain types of serious incidents be reported immediately to the VISN, such as wrong site surgery.[3] The report to the VISN is to include a brief statement of the event, current status, actions, progress, and resolution date. Events, such as wrong site surgery, also require NCPS notification through the use of the electronic Critical Incident Tracking Notification (CITN) system.[4] When CITNs are issued, designated staff at the facility, including the PSM, are to be notified.[5]

Peer Review

Peer reviews, carried out by an individual or a select committee of professionals, evaluate the performance of other professionals and make recommendations of actions necessary to improve quality of care. VHA policy requires that initial peer reviews be completed within 45 days of a qualifying event.[6] If further reviews are necessary, they are to be completed within 120 days. At this facility, the Risk Manager[7] (RM), in conjunction with the Chief of Staff, reviews incidents to determine if a peer review is indicated.

Allegations

The anonymous complainant(s) reported the following:

- Since 2013, four patient falls resulted in serious injuries on the medical units and in the community living center (CLC)[8]. The CLC patients were not evaluated timely, and a patient's care post fall was not managed appropriately. The incidents of two patients who died after they fell were not appropriately investigated.

- A patient missed a scheduled chemotherapy treatment because no chemotherapy certified nurses were scheduled to perform this, the facility opted not to call in a nurse and pay overtime, and the chief nurse did not feel it needed to be reported as a medication error or disclosed to the patient.

- A patient was placed in the medical intensive care unit and had to have emergency surgery to save his arm because medications were given through a small intravenous catheter, as a central intravenous line was not inserted when the patient had a cardiac arrest in the operating room (OR). The patient's death was not properly reported or investigated.

[3] VISN 8 Memorandum 10N8-2011-06, *VISN 8 Incident Reporting Policy*, September 2011.
[4] DUSHOM Memorandum, *Critical Incident Tracking Notification*, August 4, 2010.
[5] Ibid.
[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[7] A hospital risk manager assists in the identification, evaluation, and correction of potential risks that could lead to injury to patients, staff members, or visitors and result in property loss or damage.
[8] The community living center, formerly known as the Nursing Home Care Unit, is a part of the medical center providing long-term care, hospice, and non-acute rehabilitation.

- An ophthalmologist routinely prelabeled eye implants in order of surgical cases scheduled. A surgical case was cancelled, and the next patient had the wrong implant placed in his eye because the operative team failed to perform the time-out process[9] and used prelabeled implants meant for another patient.

- Facility leadership, including the Quality Management (QM) Service, took actions to cover up the above events and failed to disclose accurate QM and patient safety data to VISN 8. One staff member in QM assisted in cover-ups and was protected by facility leadership.

Scope and Methodology

We conducted a site visit May 27–29, 2014. We interviewed staff at the facility and VISN with knowledge of the allegations, including clinical staff from Surgery Service, Nursing Service, Geriatrics and Extended Care Service, and QM.

We reviewed VHA, VISN, and local policies; committee minutes; QM documents; and other relevant documents. The complainant did not provide specific patient information; however, in the course of our document review, we identified four patients who closely matched the four patients who had falls and three patients who had events identical to the events as described in the allegations. We reviewed the electronic health records (EHRs) of all seven patients.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[9]Time out is a process that must be conducted prior to starting a procedure. Using a checklist, the team verifies: patient identity, the correct side and site of surgery, presence of a valid consent, agreement on the procedure to be done, marking of the procedure site, correct patient position, and availability of the correct implant.

Inspection Results

Issue 1: Patient Falls

We did not substantiate that events related to patient falls resulting in injury and the deaths of two patients were not reported. We found that the PSM initiated investigations for all of the patients reviewed; however, one of the seven reviews was not timely (Patient 4). We also found that, based on EHR review, the care provided for these patients who fell was appropriate.

NCPS and local policy define a fall as "a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor or ground or hitting another object like a chair or stair." The facility had a fall prevention program in place that included a falls risk assessment upon admission, discharge, or change in condition. Fall prevention interventions were to be initiated for patients identified by the assessment to be high risk for a fall. Some of the facility fall prevention measures included non-slip socks, bed or chair alarms, floor mats, and frequent checks on patients. At this facility, a templated progress note is required to document falls, which allows notification to the PSM of the event.

Patient Falls and Deaths

Patient 1. In October 2013, the patient was admitted to a medical unit with end stage esophageal cancer and a "do not resuscitate" order. Hospice was requested on the day of admission. According to the EHR, during the night, the patient was being assisted to the bathroom, stumbled, and fell onto the nursing assistant and into a trashcan. A post-fall assessment was done by the nursing staff, but a physician was not contacted as required by local policy. Approximately 2 hours later, the patient stopped breathing and a physician was contacted. The physician evaluated the patient shortly after death and concluded that the fall did not contribute to the patient's death. The PSM took appropriate action and initiated an assessment within 24 hours. The PSM recommended that an RCA be completed, and peer reviews were initiated within 45 days.

Patient 2. In February 2014, the patient fell in the CLC and sustained a right hip fracture. The patient had a past medical history of falls, congestive heart failure, chronic renal failure, chronic obstructive pulmonary disease, and vertigo. The patient was evaluated by a physician on duty immediately after the fall and was found to be medically stable. Radiology results several hours later showed a hip fracture. Providers determined that the patient was not a candidate for surgical repair of the fracture. Later in the day, the patient reported chest pain and was promptly evaluated. A physician determined that the patient suffered an acute myocardial infarction (heart attack). He was treated appropriately in the medical intensive care unit for 13 days and then moved to hospice. He died later that morning. The PSM was notified immediately after the patient fell, initially evaluated the incident as no injury, and re-evaluated the situation 14 days later after learning of the change of the patient's status. Initial peer reviews were completed within 45 days.

Patient Falls with Injury

Patient 3. In January 2014, the patient fell on a medical unit and sustained a right hip fracture. Four days later, he underwent surgical repair of the fracture and was discharged to the CLC for continued therapy. The PSM initiated a review the day after the patient fell. The review was completed 5 days after the fall.

Patient 4. In January 2014, the patient fell outside the facility. He was evaluated in the emergency department and found to have a fractured right hip. He underwent surgical repair of the fracture the next day and was discharged to a community rehabilitation center 5 days after the surgery. A patient incident worksheet (PIW) was not completed as required, so the PSM was not notified timely and did not review the case until 6 days after the incident.

Patient 5. In February 2014, the patient fell on a medical unit and sustained a fracture of the right hip. The patient had a history of pneumonia and was admitted for treatment of this condition. He underwent surgical repair of the fracture 3 days after the incident and was discharged for rehabilitation in March. The PSM was notified immediately following the fall and reviewed the incident on the same day.

Patient 6. In March 2014, the patient fell in the CLC, sustained a left hip fracture, and was transferred to an acute care unit. The patient had a history of metastatic cancer with multiple comorbidities. The oncology and orthopedic physicians advised that medical management was the best treatment option, and the patient was transferred back to the CLC for care. The PSM was notified immediately after the fall and completed a review of the incident within 2 days.

Patient *7.* In April 2014, the patient fell in the CLC and sustained a fracture at the neck of the left femur. Surgery was not recommended, as the patient was already in hospice care at the time of the incident. The PSM was notified immediately and reviewed the incident within 24 hours.

Issue 2: Chemotherapy Administration

We did not substantiate the allegation that a patient missed a scheduled chemotherapy treatment because a chemotherapy certified nurse was not scheduled, and the facility opted not to call in a nurse and pay overtime. We did, however, find that the chemotherapy treatment was delayed and that the delay in receiving care was not reported by nursing staff or management to the PSM as required.

We interviewed staff familiar with the incident and reviewed staffing data at the time of the incident. The patient had received part of his final chemotherapy infusion during the evening shift, but the two scheduled chemotherapy certified nurses called in sick for the night shift. The unit nurse manager, when notified of the situation, determined that the chemotherapy infusion could be stopped with no adverse effects and resumed with no adverse effects the next morning; therefore, a staff member certified in chemotherapy was not needed until the next day.

The oncologist was contacted in the morning and documented that there was "no negative impact" to the patient as long as the final treatment was administered. We confirmed that the chemotherapy treatment was completed the next morning.

The unit nurse manager notified the chief nurse of the incident; however, the PSM was not informed about the incident until 59 days later when the VISN contacted the facility after receiving the letter with these allegations. Consequently, appropriate actions were significantly delayed.

At the time of this incident, the facility was understaffed with nurses certified to provide chemotherapy treatment. The May 2014 nursing schedule for the oncology unit showed an increase in certified nurses since this incident occurred.

Issue 3: Intra-Operative Resuscitation of a Cardiac Patient

We did not substantiate the allegation that a patient had emergency arm surgery because medications were given through a small peripheral intravenous line instead of a central intravenous line during a cardiac arrest in the OR, and the patient's death was not properly reported or investigated. However, we found that the resuscitation event was not reviewed as required.

VHA requires that every cardiopulmonary resuscitation (CPR) event be reviewed by a facility level Cardiopulmonary Resuscitative Committee (CRC).[10]

At this facility, "code blue" refers to an event when a patient requires CPR. Local policy requires that a specific EHR progress note be used to document resuscitation events. Use of this progress note automatically alerts the facility's RM that a code blue event occurred so required reviews can be arranged.

The patient was admitted for an elective pacemaker implant procedure. A small peripheral intravenous catheter was in place during the procedure. The patient suffered a cardiac arrest after the procedure, but while still in the OR. A central intravenous catheter was inserted during resuscitation efforts. He survived the resuscitation efforts in the OR and was transferred to the medical intensive care unit in very critical condition. Eleven days later, life support was discontinued and the patient died. Peer reviews were completed.

We found that the correct progress note was not used to document the resuscitation event. Instead, documentation of the code blue was done in a separate electronic system used by anesthesia personnel, which was later scanned into the EHR. As a result, the RM was not alerted to the event, and the CRC did not review the resuscitation event as required.

[10] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees,* October 17, 2008.

Issue 4: Intra-Operative Medical Error in an Ophthalmologic Patient

We substantiated the allegation that a patient had the wrong lens implant placed in his eye during cataract surgery because the operative team failed to properly perform the time-out process. We were unable to determine if it was a routine practice for the surgeon to pre-label implants.

VHA policy requires that ophthalmologic intraocular lens implant procedures must include a time out process prior to the procedure.[11] The time out is to include verification of the lens implant style, power, and expiration date.

Prior to initiation of the cataract surgery, the surgeon documented that a time-out was done; however, we were told that the surgeon and the operative nurses did not verify that the correct lens was available prior to the procedure as required. The error was noticed after the procedure was completed and the patient had been transferred to the post anesthesia care area. The patient was informed of the error and consented to have the correct lens inserted promptly.

The facility immediately sent a CITN to the VA National Surgery Office as required. We reviewed the documentation and found that the PSM was not included on the alert and did not learn of the event and initiate a review until 4 days later.

Surgery Service completed a review of the event 2 months later and recommended that the case be further reviewed by the Morbidity and Mortality Committee. However the case was not reviewed until 6 months later, while we were onsite and inquired about results of the review.

Issue 5: Reporting Patient Safety Issues

We did not substantiate the allegation that facility staff "covered up" or failed to disclose events to VISN 8. Once the PSM was made aware of the patient safety concerns mentioned in the allegations, the incidents were reviewed and reported to VISN 8 as required by local, VISN, and VHA policy.

Although not an allegation, we identified that the internal reporting process was flawed, causing lack of and/or delayed reporting of patient safety concerns to the PSM.

Local Reporting. Local policy requires that incidents be reported to the PSM within 24 hours to 3 working days, depending upon the severity of the incident. This allows the PSM to take appropriate actions and initiate reviews in a timely manner.

The facility uses a dual system to report patient safety incidents. Since October 2013, patient falls are documented in the EHR on a specific progress note template. Use of this note triggers an alert to the PSM and the facility's falls coordinator to ensure a

[11] VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.

timely review. We found that this process was followed when we reviewed the EHRs of patients who fell.

All other types of incidents, including unsafe conditions, are reported on a paper form called the PIW. According to local policy, completed PIWs are to be turned in to the staff's supervisor. The supervisor is to then notify the QM Service and/or the PSM of the event. We found that in the facility's nursing service, PIWs are instead being routed from the nurse supervisor to the chief nurses and then the Associate Director for Patient Care (Nurse Executive) before they are reported to the PSM. Furthermore, we found that managers may do a service-level review and decide that the incident does not need to be reported to the PSM, who is, according to VHA policy, to complete the initial review. PIWs are not tracked until they reach the Associate Director for Patient Care, so it is unknown how many are completed by staff but not reported to the PSM as required.

The PSM and other QM staff agreed that the current process has vulnerabilities with the potential for PIW forms to be delayed or lost. We found significant delays in incident reporting. According to data provided to us, in fiscal year (FY) 2013, 1,384 incidents were reported, with an average time of 18 days from the occurrence of the incident to PSM notification. In FY 2014 through May 28, 2014, 918 incidents had an average time of 13 days from occurrence until PSM notification.

Issue 6: Additional Finding – QM Staffing Issues

At the time of our visit, we found that the QM Service was severely understaffed, with 9 of 18 full-time positions vacant. The service has had an Acting Chief for over 18 months. One staff member had been acting as the PSM in addition to her other job responsibilities for 12 months. Another staff member had been acting as the RM in addition to her regular duties for 8 months. We were told that active recruitment for the positions was in progress at the time of our review.

We found that facility leadership took action in response to recommendations made in both internal and external reviews about personnel issues within the service. These reviews and actions taken were shared with the VISN.

Conclusions

We did not substantiate that events related to patient falls resulting in injury and death of two patients were not reported or investigated. However, we found investigations were not timely for one of the seven patients we reviewed. We also found that, based on EHR review of the patients we identified, the care provided for the patients was appropriate.

We did not substantiate the allegation that a patient missed a scheduled chemotherapy treatment because a chemotherapy certified nurse was not scheduled, and the facility opted not to call in a nurse and pay overtime. We did find, however, a delay occurred in completing the chemotherapy treatment, and the delay was not reported to the PSM as

required. The incident was reported to the chief nurse through email but was not referred to the PSM, a process that circumvented the VHA patient safety process for reporting, tracking, and taking appropriate actions on patient safety concerns.

We did not substantiate the allegation that a patient was placed in the medical intensive care unit and required emergency surgery on his arm because medications were administered through a small intravenous catheter or that the patient's death was not properly reported or investigated. While reviewing the circumstances of the cardiac arrest, however, we found that the correct progress note was not used to document the resuscitation event. As a result, the RM was unaware of the event and did not initiate a required review.

We substantiated the allegation that a patient had the wrong lens implant placed in his eye during cataract surgery because the operative team failed to perform the time-out process. We were unable to determine if it was a routine practice for the surgeon to pre-label implants. The PSM was not notified of the incident immediately through the CITN system, and the incident was not reviewed by the Morbidity and Mortality Committee as recommended until 6 months later, while we were onsite.

We did not substantiate the allegation that facility staff "covered up" or failed to disclose events to VISN 8. Once the PSM was made aware of the patient safety concerns mentioned in the allegations, the incidents were reviewed and reported to VISN 8 as required by local, VISN, and VHA policy. We found that the facility reporting process for patient incidents and/or safety concerns did not comply with VHA policy. The current system of requiring reports to go through layers of nursing management before reaching the PSM causes unnecessary delays and missed opportunities for early intervention.

Although not an allegation, we also determined that QM Services has been chronically understaffed, an issue that has been identified in previous reviews.

Recommendations

1. We recommended that the Facility Director ensure that patient safety incidents and concerns are reported promptly to the patient safety manager and that the need for further review and/or corrective actions is assessed initially by the patient safety manager.

2. We recommended that the Facility Director ensure that cardiac resuscitation events in the operating room are appropriately documented and reviewed.

3. We recommended that the Facility Director ensure that the Critical Incident Tracking Notification system recipient list includes the patient safety manager.

4. We recommended that the Facility Director assess staffing in the Quality Management Service and take appropriate actions to meet the workload requirements.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 4, 2014

From: Director, Veterans Integrated Service Network (10N8)

Subj: **Draft Report**— Healthcare Inspection-Quality of Care Issues West Palm Beach VA Medical Center, West Palm Beach, FL

To: Associate Director, Region Office of Healthcare Inspections (54SP)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

Thank you for your onsite review and evaluation. I have reviewed your report and concur with the findings and recommendations.

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

(original signed by:)

Joleen Clark, MBA, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 3, 2014

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

Subj: **Draft Report**—Healthcare Inspection-Quality of Care Issues West Palm Beach VA Medical Center, West Palm Beach, FL

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

West Palm Beach VA Medical Center (WPB VA MC) would like to thank the Office of Inspector General (OIG) Team for the recommendations based on their assessment during the on site visit conducted May 27–29, 2014.

Our goal is to deliver the best care to our Veterans each and every day focusing on Quality, Safety, and Value and we appreciate the OIG Team's consultative and collaborative approach in helping us to meet our goal.

Charleen R Szabo, FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that patient safety incidents and concerns are reported promptly to the patient safety manager and that the need for further review and/or corrective actions is assessed initially by the patient safety manager.

Concur

Target date for completion: 01-01-2015

Facility response: WPB is currently developing an electronically entered Patient Incident Worksheet (PIW), where the initial reporting portion identifying what happened (actual event) or what could have happened (near miss) is summarized in a standardized reporting tool. This tool will be accessed using a desktop icon and its use will be mandated in the revision of MCM 548-99-259 Patient Incident Review Program. The MCM will be posted when all staff has been educated on the mandated changes.

When the recorder completes the initial findings electronically and requests the report to print, the report will print on the printer requested by the person reporting the incident and it will automatically print on the network printer for the Patient Safety Manager (PSM). This will ensure all initial reports for incidents that are reported using the mandated PIW will be printed in real time to the PSM. This will allow the PSM to review the initial statement and complete the Safety Assessment Code (SAC) identifying the probability and severity of injury to each event timely.

Recommendation 2. We recommended the Facility Director ensure that cardiac resuscitation events in the operating room are appropriately documented and reviewed.

Concur

Target date for completion: 11-7-2014

Facility response: At the time of the site visit, policy 548-111-81 Code Blue Pulmonary Resuscitation Response Team existed and the policy was not followed for a Code Blue that occurred in the operating room. The existing policy stated:

"*Following the completion of each Code Blue, a team member designated by the team leader will arrange for the debriefing within twenty-four hours and a debriefing report will be presented to Quality Management for quarterly report to the Cardiopulmonary Resuscitation Committee (aka CPR Committee).*"

All OR Anesthesia staff is required to attend the mandatory interactive staff meeting on 11-7-2014. The Attendance Sheet and Minutes will support the Chief of Anesthesiology outlined identified expectations and answer questions regarding MCM 548-111-81 to include: how to call a Code Blue to operator; direction required of OR staff to responding Code Blue staff i.e. applying paper coverall and mask; OR staff responsibilities during Code Blue; proper documentation using Code Blue Note Title in CPRS; review of Attachment C - *CPR Documentation form*, and use of Attachment B of MCM *Code Blue Response Performance Improvement Checklist* after every Code Blue in the OR.

ALL OR Nursing staff attended an in-service on 10-17-2014 provided by the OR Nurse Manager (NM) to outline the identified expectations. This education is recorded in TMS #VA3892983.

The Chief of Anesthesiology in collaboration with the OR NM will conduct a review of all Code Blue events occurring in the OR and the OR NM will record the findings in a spreadsheet so that events can be tracked and trended over time. OR Code Blue Reporting will be identified as a standing agenda item for the OR Committee and will be reported monthly by the OR NM beginning in November. When OR staff follows MCM 548-111-81, the resulting consistent process will ensure that the CPR Committee will review the event which will be supported in their Minutes because the Risk Manager will receive the Checklist in Quality Management.

Recommendation 3. We recommended that the Facility Director ensure that the Critical Incident Tracking Notification system recipient list includes the patient safety manager.

Concur

Target date for completion: 10-22-2014

Facility response: The facility reviewed the Memo sent August 4, 2010 from the Deputy Under Secretary for Health for Operations and Management to ensure all required individuals and offices are identified to receive the CITN Notification. An Outlook e-mail group was established on 10-20-14 entitled VHAWPB CITN to include all required individuals. To verify compliance, a monthly reminder (4th Wednesday of the month) has been placed on the VA Surgical Quality Improvement Program Coordinator's calendar to validate VHAWPB CITN e-mail group correctly identifies the Facility PSM, Facility Chief of Staff, VISN CMO, VISN Chief Surgical Consultant, VISN PSO, Office of the NCPS and NSO are current. The first date for verification was 10/22/2014, all required staff was listed and compliance will be reported monthly for FY15 to the OR Workgroup as a standing agenda item beginning November 2014. Request to close based on actions and monthly reporting for compliance.

Recommendation 4. We recommended that the Facility Director assess staffing in the Quality Management Service and take appropriate actions to meet the workload requirements.

Concur

Target date for completion: 06-01-2015

Facility response: The Quality Management Service continues to be challenged to fill vacant positions with qualified candidates. Positions are posted, interviews conducted and selections are made and positions are offered timely based on resume/curriculum vitae review, interviews and reference checks. All key vacant positions have had selections made and jobs were offered but then jobs were declined (Chief, Patient Safety Manager, Risk Manager, and Utilization Specialist and the Administrative Officer) for a myriad of personal reasons.

Quality Management will continue to move forward with recruitment until all positions are filled. Resource Management Committee has approved the following new positions; one additional Risk Manager, two Utilization Management positions and one Patient Safety Specialist. QM completed the interviews for the Risk Manager positions on 10/27/14. The first candidate selected and accepted the position and will convert from Acting Risk Manager to Risk Manager this pay period. This applicant had been a UM RN so that has also added to the vacancy rate. The second candidate selected on 10/27/14 provided an immediate supervisor reference on 10/29/14 and we have called and are awaiting a return call.

One Quality Management Specialist retired in February 2014 and the position was posted and filled in March 2014.

Quality Management has acquired the Controlled Substance Coordinator formerly under Patient Care Services and that position was posted and filled by one of the RNs that formerly was a Utilization Management Specialist which added to that vacancy.

An Administrative Officer from another VA was selected and accepted the position with a start date in October. The week after she accepted the QM position she interviewed in WPB Patient Care Services for a higher GS position and accepted that position a week after her QM start date.

One of the three Utilization Management positions has been filled by a permanent detail. Two additional people were selected but one of those selected declined. One UM staff was selected on 10/29/14 and we are waiting for notification by HR. If the person selected on 10-29-14 accepts the position we will have one vacancy in UM and the position will be reposted the week of 11/3/14.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

Report Distribution

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Director, VA Sunshine Healthcare Network (10N8)
Director, West Palm Beach VA Medical Center (548/00)

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